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# Mental Health Advance Directives: Having One's Say?

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# Mental Health Advance Directives: Having One's Say?

BY JUSTINE A. DUNLAP\*

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## I. INTRODUCTION

“She has decided that she has the right to do the wrong thing. It is, after all, her death.”<sup>1</sup> Alice Hoffman’s words from her novel *Illumination Night* embody the legal principles of bodily integrity and autonomy.<sup>2</sup> The words could be modified to “She has decided that she has the right to do the wrong thing. It is, after all, her *life*,” and still retain their legal vitality.<sup>3</sup> The right of bodily integrity and its companion, the right to refuse medical treatment, are well-ingrained in American jurisprudence.<sup>4</sup> These rights protect a person’s ability to control

<sup>1</sup> ALICE HOFFMAN, *ILLUMINATION NIGHT* 161 (1987).

<sup>2</sup> This protection from unwelcome bodily intrusion has roots as far back as fourteenth century English common law. See F.W. MAITLAND, *THE FORMS OF ACTION AT COMMON LAW: A COURSE OF LECTURES* 56 (A.H. Chaytor & W.J. Whittaker eds., Cambridge Univ. Press 1968) (1909).

<sup>3</sup> “Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.” 2 FOWLER V. HARPER & FLEMING JAMES, JR., *THE LAW OF TORTS* § 17.2, at 61 (Supp. 1968).

<sup>4</sup> “The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.” *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 270 (1990). One commentator refers to the obsession and preoccupation with autonomy, asserting that “courts . . . seem almost frantic in insisting on its preeminent role.” Rebecca Dresser, *Missing*

what is done to his or her body and have been expanded to include the making of prospective choices through the vehicle of advance directives for medical care.<sup>5</sup> This Article explores the extension of advance directives to psychiatric treatment.<sup>6</sup>

First, this Article traces the extension of the right to refuse treatment to the psychiatric realm.<sup>7</sup> Next, the Article addresses advance directives for health care<sup>8</sup> and their utility for mental health issues.<sup>9</sup> Then, the Article examines state statutory and judicial responses to mental health advance directives.<sup>10</sup> Finally, the Article analyzes why the right to control future psychiatric treatment, including the right to refuse treatment, has been slow to gain acceptance.<sup>11</sup> Although mental health advance directives present real challenges, legally and otherwise, this Article concludes that they are firmly rooted in the law and their rejection is, more often than not, based on illegitimate grounds.

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*Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 611 (1994).

<sup>5</sup> As the making of future choices often involves the decision to refuse treatment, the right to refuse and advance directives are directly connected. This is especially true with respect to advance directives for mental health decisions.

<sup>6</sup> There have been several writings on this topic over the last two decades. See generally Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777 (1982); Thomas S. Szasz, *The Psychiatric Will: A New Mechanism for Protecting Persons Against "Psychosis" and Psychiatry*, 37 AM. PSYCHOLOGIST 762 (1982); Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57 (1996).

<sup>7</sup> See *infra* notes 12-112 and accompanying text.

<sup>8</sup> This tool has several names, including "durable power of attorney for health care" and "health care proxies." Advance directives became increasingly popular after the *Cruzan* decision highlighted their utility. Further, in 1990, Congress passed the Patient Self-Determination Act, 42 U.S.C. § 1395cc (1994), which requires health care providers to inquire of patients whether they have executed an advance directive.

<sup>9</sup> See *infra* notes 113-286 and accompanying text.

<sup>10</sup> See *infra* notes 287-343 and accompanying text.

<sup>11</sup> See *infra* notes 344-98 and accompanying text. This reluctance to endorse mental health advance directives has been recognized elsewhere. See Lester J. Perling, Comment, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. MIAMI L. REV. 193, 197 (1993). The comment suggests that the not-so-secret desire to control persons with mental illness may be one of the reasons that mental health advance directives are not fully embraced. See *id.*

## II. THE RIGHT TO REFUSE TREATMENT

### A. General Principles

The right to bodily integrity originated centuries ago<sup>12</sup> and led to the right of informed consent<sup>13</sup> and the right to refuse treatment.<sup>14</sup> The right to refuse treatment has developed and expanded slowly over a period of decades and is now bedrock legal doctrine.<sup>15</sup> It applies to different medical conditions, including psychiatric care.<sup>16</sup>

The right to refuse treatment does not evaporate upon the loss of competence.<sup>17</sup> Although incompetent persons lack the present *ability* to

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<sup>12</sup> Maitland traces its roots to fourteenth century English common law. See MAITLAND, *supra* note 2, at 56. In an early case regarding the right to bodily integrity in this country, Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

<sup>13</sup> See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977) (stating that "[o]ne means by which the law has developed in a manner consistent with the protection of this interest [of bodily integrity] is through the development of the doctrine of informed consent"); W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 18 (5th ed. 1984).

<sup>14</sup> See *In re President and Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1010, 1013 (D.C. Cir. 1964) (Miller, J., dissenting); *In re Conroy*, 486 A.2d 1209, 1221-23 (N.J. 1985); *In re Quinlan*, 355 A.2d 647, 662-64 (N.J. 1976).

<sup>15</sup> The evolution of the right involved its application to increasingly complicated medical situations. Over time, the right extended to persons who were not terminally ill and to persons not presently competent to exercise the right. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 276 (1990); *John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984); *Guardianship of Doe*, 583 N.E.2d 1263, 1267 (Mass. 1992); *Quinlan*, 355 A.2d at 657. Courts have differed on the basis for the right. Some have found a liberty interest under the Due Process Clause. See *Cruzan*, 497 U.S. at 262. Others have found the right to repose in privacy interests. See *Saikewicz*, 370 N.E.2d at 424. To say that there is a right is not to suggest it is absolute. For a discussion of when the right can be abridged, see *infra* note 39 and accompanying text.

<sup>16</sup> See *Riggins v. Nevada*, 504 U.S. 127, 133-35 (1992); *Washington v. Harper*, 494 U.S. 210, 221-23 (1990); *Rogers v. Okin*, 634 F.2d 650, 653-54 (1st Cir. 1980).

<sup>17</sup> The terms competent and incompetent are open to a host of meanings and synonyms. See Winick, *supra* note 6, at 66. A helpful distinction, adopted for this paper, is the concept of competence as a legal status—whether or not a court adjudication is actually involved. See John W. Parry, *The Court's Role in*

decide and to instruct medical caregivers, they still possess the *right*, which may be exercised in one of two ways. The first, which is the concern of this Article, is through the vehicle of advance directives. The second option is the doctrine of substituted judgment, a process by which a third party attempts to discover what an incompetent person would have decided if competent.<sup>18</sup> Although incompetent persons have the right to refuse treatment, the exercise of the right for that group of persons is more difficult than it is for competent persons.<sup>19</sup>

## *B. The Extension of the Right to Refuse Treatment to Psychiatry*

### *1. Introduction*

The right to refuse treatment exists as surely for psychiatric illness as it does for physical illness.<sup>20</sup> Various courts, including the U.S. Supreme

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*Decisionmaking Involving Incompetent Refusals of Life-Sustaining Care and Psychiatric Medications*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 468, 468 (1990). Incapacity is the medical condition of the person that leads to a conclusion or declaration of incompetence. *See id.* Further, competence is often considered a legal determination, while capacity is a medical determination. *See id.* Unfortunately, however, these terms are interchanged indiscriminately, including in places, such as statutes, where precise language matters. The type of advance directive selected may control how the directive takes effect, through a court determination of incompetence or by one or more physicians determining a lack of decision-making capacity. *See Alan D. Lieberman, Advance Medical Directives—1998: A Medical View*, 12 QUINNIPIAC PROB. L.J. 305, 329 (1998).

<sup>18</sup> The substituted judgment approach is an effort to preserve personal autonomy and bodily integrity, as it focuses on what a person would have chosen, if competent, as contrasted to what is in the person's best interest. In recognizing the subjectivity of medical choices, the New Jersey Supreme Court in *In re Peter* stated:

Medical choices are private, regardless of whether a patient is able to make them personally or must rely on a surrogate. They are not to be decided by societal standards of reasonableness or normalcy. Rather, it is the patient's preferences—formed by his or her unique personal experiences—that should control.

*In re Peter*, 529 A.2d 419, 423 (N.J. 1987). The court further explained that the privacy accorded to medical decisions "does not vary with the patient's condition" and that the condition is relevant only to the determination of competence. *Id.*

<sup>19</sup> Indeed, the U.S. Supreme Court in *Cruzan*, which established the right on a federal constitutional level, noted the differences and concerns present when the right is being applied to an incompetent. *See Cruzan*, 497 U.S. at 277-81.

<sup>20</sup> *See Riggins*, 504 U.S. at 133-35; *Harper*, 494 U.S. at 221-23; *Vitek v. Jones*, 445 U.S. 480, 493-94 (1980).

Court, have over the past four decades carved out rights for persons with mental illness.<sup>21</sup> Implicit or explicit in these decisions is the right to refuse the forced administration of psychotropic drugs.<sup>22</sup> The right has been recognized in a variety of contexts, the most controversial being involuntary civil commitments. Courts are divided on this issue, but many have held that even persons institutionalized through involuntary commitment proceedings retain the right to refuse the forced administration of psychotropic drugs<sup>23</sup> or other involuntary treatment.<sup>24</sup>

The existence of the right helps shape the debate, of course, but it raises more questions than it answers. For instance, what is the basis for and extent of this right? Is it a common law<sup>25</sup> or constitutional right?<sup>26</sup> And if the right is a constitutional right, does it rise to the level of a *fundamental*

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<sup>21</sup> See *Foucha v. Louisiana*, 504 U.S. 71, 75-80 (1992); *Vitek*, 445 U.S. at 487-94; *Addington v. Texas*, 441 U.S. 418, 425-33 (1979); *O'Connor v. Donaldson*, 422 U.S. 563, 572-76 (1975).

<sup>22</sup> See *Vitek*, 445 U.S. at 480, 491-94. For a partial listing of articles and commentary on the topic, see *In re C.E.*, 641 N.E.2d 345, 350-51 (Ill. 1994). The right to refuse further treatment extends to electroconvulsive therapy. See *In re Hatsuye T.*, 689 N.E.2d 248 (Ill. App. Ct. 1997); *In re Rosa M.*, 597 N.Y.S.2d 544, 545 (N.Y. Sup. Ct. 1991); see also *infra* Part IV.B.

<sup>23</sup> Psychotropic drugs are defined as "pharmacological agents used to treat psychiatric disorders." 2 KAPLAN AND SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2241 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000). The terms "psychotropic drugs," "psychoactive drugs," and "psychotherapeutic drugs" may be used interchangeably. See *id.*

<sup>24</sup> See *Walters v. W. State Hosp.*, 864 F.2d 695, 697-98 (10th Cir. 1988); *Davis v. Hubbard*, 506 F. Supp. 915, 925-39 (N.D. Ohio 1980); *Rivers v. Katz*, 495 N.E.2d 337, 341-42 (N.Y. 1986). For a listing of literature on the subject, see Alexander D. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339, 339 n.1 (1987).

<sup>25</sup> See Jessica Litman, Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720 (1982).

<sup>26</sup> Professor Richard Bonnie suggests that the right to refuse psychiatric medication derives not from the common law (as does the general right to refuse, which has its basis in malpractice doctrine), but rather from constitutional rights identified during the 1970s respecting persons with mental illness. See Richard J. Bonnie, *The Psychiatric Patient's Right to Refuse Medication: A Survey of the Legal Issues*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS: VALUES IN CONFLICT 19, 19-21 (A. Edward Doudera & Judith P. Swazey eds., 1982). Of course, this was written well before the *Cruzan* case constitutionalized on a federal level the right to refuse life-sustaining medical treatment.

one?<sup>27</sup> Some have suggested First Amendment protections<sup>28</sup> and the U.S. Supreme Court has found a liberty interest in the prison context.<sup>29</sup> Regardless of the source, are there circumstances under which the right can be abridged? If so, when?

## 2. Development of the Right

More than two decades ago, the cases of *Rennie v. Klein*<sup>30</sup> and *Rogers v. Okin*<sup>31</sup> significantly advanced the right to refuse psychiatric treatment. These cases are a good starting point to understand the right to refuse mental health treatment.

John Rennie, a divorced former pilot and flight instructor,<sup>32</sup> was diagnosed as a person with paranoid schizophrenia.<sup>33</sup> He had been admitted

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<sup>27</sup> In *Riggins v. Nevada*, although the Court did not specifically reach the issue, the Court did suggest that perhaps the right is fundamental. See *Riggins v. Nevada*, 504 U.S. 127, 133-38 (1992). Some commentators have argued and some courts have held that the right to refuse is indeed fundamental. See *Davis*, 506 F. Supp. at 934; William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 989-93 (1998); Winick, *supra* note 6, at 63-64.

<sup>28</sup> See Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 319-26 (1992). In *Rennie v. Klein*, the trial court rejected the First and Eighth Amendments as grounds for the right. See *Rennie v. Klein*, 462 F. Supp. 1131, 1143-44 (D.N.J. 1978). In *Rogers v. Okin*, however, a federal district court found that First Amendment rights were implicated. See *Rogers v. Okin*, 478 F. Supp. 1342, 1366-67 (D. Mass. 1979).

<sup>29</sup> See *Riggins*, 504 U.S. at 127; *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>30</sup> *Rennie v. Klein* had a rather complicated procedural history. See *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978) (denying preliminary injunction); *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), *stay granted* by 481 F. Supp. 552 (D.N.J. 1979), *reh'g en banc granted*, *opinion vacated* by 653 F.2d 836 (3d Cir. 1981), *cert. granted*, *judgment vacated* by 458 U.S. 1119 (1982), *remanded to* 720 F.2d 266 (3d Cir. 1983).

<sup>31</sup> Like *Rennie*, *Rogers v. Okin* was procedurally complicated. See *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *modified* by 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. by Mills v. Rogers*, 457 U.S. 291 (1982), *remanded to and modified by Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984).

<sup>32</sup> This level of detail, while perhaps appearing irrelevant, helps to underscore the power of labels and stigma. Mr. Rennie was more than just mentally ill. The reader is likely to have a different, more favorable reaction towards Mr. Rennie if he is described with the common, humanizing characteristic of being divorced and as having the skills necessary to be a flight instructor, rather than just labeled as a "paranoid schizophrenic," with all the fears that diagnosis summons. See *infra* notes 360-69 and accompanying text for a discussion of sanism.

<sup>33</sup> *Rennie*, 653 F.2d at 838.



a dozen times to the state hospital in New Jersey and had been both involuntarily committed and involuntarily medicated.<sup>34</sup> During his involuntary commitment, Mr. Rennie filed suit against various state actors, alleging that the administration of antipsychotic drugs against his will was a violation of his constitutional rights.<sup>35</sup>

After several proceedings at the federal district court level, the Court of Appeals for the Third Circuit held that persons involuntarily committed to state mental hospitals retain a Fourteenth Amendment due process liberty interest to refuse antipsychotic drugs that have the potential to cause permanent and disabling side effects.<sup>36</sup> The court declared "that there is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs."<sup>37</sup> Forced medication "implicates the 'right to be free from . . . unjustified intrusions on personal security.'"<sup>38</sup> Not surprisingly, it found that the right to refuse antipsychotic drugs was not absolute and could be abridged at times based upon the valid exercise of the state's police or parens patriae power, provided it was done with the least intrusive infringement on the right.<sup>39</sup>

A year later in 1982, the U.S. Supreme Court vacated the court of appeals's opinion and remanded<sup>40</sup> for further consideration in light of *Youngberg v. Romeo*,<sup>41</sup> a case involving the involuntary physical restraint of an institutionalized patient.<sup>42</sup> The Court in *Youngberg* rejected—or, at a minimum, found inapplicable—the least intrusive means standard and, instead, carved out a standard of review of mental health treatment decisions that was quite deferential to professional medical decision-making.<sup>43</sup> On remand, the First Circuit issued a splintered deci-

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<sup>34</sup> *Id.*

<sup>35</sup> *See id.* at 838-39.

<sup>36</sup> *See id.* at 838-44.

<sup>37</sup> *Id.* at 844.

<sup>38</sup> *Id.* (citing *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)).

<sup>39</sup> *Id.* at 845.

<sup>40</sup> *Rennie v. Klein*, 458 U.S. 1119 (1982).

<sup>41</sup> *Youngberg v. Romeo*, 457 U.S. 307 (1982).

<sup>42</sup> *See id.* at 311.

<sup>43</sup> *See id.* at 323. *Youngberg*'s professional judgment standard has led to much consternation in patient-advocate circles, as it affords significant discretion to medical determinations and permits judicial reversal only if a decision is not made consistent with standards of professional judgment. *See id.* Although *Youngberg* was not decided in a refusal to medicate setting, it has been so applied. *See Morgan v. Rabun*, 128 F.3d 694, 697-98 (8th Cir. 1997). In discussing the defendant Dr.

sion.<sup>44</sup> Six judges found *Youngberg*'s professional judgment standard to be controlling—albeit with differing standards<sup>45</sup>—and three found that the Court's rejection of the least intrusive means test in the physical restraint context of *Youngberg* did not extend to the forced intake of psychotropic drugs upon the institutionalized mentally ill, as was the case in *Rennie*.<sup>46</sup> Reduced to its essentials, the Court of Appeals for the Third Circuit held that there was a "qualified" constitutional right to refuse psychiatric treatment and that New Jersey law did not violate those rights.

At about the same time, a similar battle was taking place in the Court of Appeals for the First Circuit. In *Rogers v. Okin*,<sup>47</sup> the named plaintiff, Rubie Rogers, and a class of individuals who were then living or had previously lived at a Massachusetts state mental health facility sued for damages and injunctive relief based upon the forced administration of antipsychotic drugs.<sup>48</sup> The First Circuit upheld what it declared to be "an intuitively obvious proposition"—that each individual has the right to be free to decide whether that individual wants to receive antipsychotic drugs.<sup>49</sup> Although the court noted that the direct source of the right was ambiguous and that direct authority for the right was scarce, it nonetheless found the right to be lurking within the Fourteenth Amendment, as part of the penumbral rights to privacy, bodily integrity, and personal security.<sup>50</sup>

The court further declared that the right to refuse was not absolute and could be overridden by a valid exercise of the state's police power after an individualized balancing test weighing the rights of the individual against the state's interest in preventing violence demonstrated that the latter interest outweighs the former and that there are no less restrictive means

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Rabun's forcible injection of psychotropic drugs into the plaintiff patient, the court stated that "we must simply make certain that Dr. Rabun exercised professional judgment" and that "[w]e start from a presumption that the decisions made by professionals are correct." *Id.* at 697-98. Some advocates have therefore concluded that state courts provide friendlier forums than do federal courts because state courts may more strictly scrutinize institutional decisions to forcibly medicate in the context of competent refusals.

<sup>44</sup> *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983).

<sup>45</sup> *See id.* at 266-74.

<sup>46</sup> *See id.* at 274-77.

<sup>47</sup> *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980).

<sup>48</sup> *Id.* at 653.

<sup>49</sup> *Id.* Indeed, the court stated that neither the parties nor any amici took issue with this general legal proposition. *Id.* at 654.

<sup>50</sup> *Id.* at 653.

available.<sup>51</sup> On the other hand, the state's *parens patriae* power could be used to override an individual's refusal to submit to medication only when there was a determination of incapacity of the individual.<sup>52</sup>

The Supreme Court granted certiorari in the *Rogers* case to answer one question: does an involuntarily committed mental patient have a constitutional right to refuse treatment with antipsychotic drugs?<sup>53</sup> The Court declined to answer the question, however, because an intervening Massachusetts state case, *Guardianship of Roe*,<sup>54</sup> premised upon both state and federal law, could have changed the result of the court of appeals's decision.<sup>55</sup> Accordingly, the Supreme Court remanded the case for a decision by the court of appeals as to whether *Roe* required it to revise its holdings or to certify state-law questions to the Massachusetts Supreme Judicial Court.<sup>56</sup>

The Court of Appeals for the First Circuit then certified nine questions to the Massachusetts Supreme Judicial Court, which found that state law created rights for involuntarily committed persons that included the right to make medical determinations.<sup>57</sup> If patients were found to be incompetent,<sup>58</sup> they would be entitled to substituted judgment decision-making.<sup>59</sup> Under this process, the decision made would be the one that, after investigation, is believed to be the one that the patient would make, and not a decision based upon a more objective "best interests" standard.<sup>60</sup>

After the Massachusetts court ruled, the First Circuit took up the case again. Another intervening U.S. Supreme Court decision complicated matters, however, by stripping federal courts of their power to order injunctive relief compelling state officials to comply with state law.<sup>61</sup>

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<sup>51</sup> See *id.* at 656-57.

<sup>52</sup> See *id.* at 657.

<sup>53</sup> *Mills v. Rogers*, 457 U.S. 291, 293 (1982).

<sup>54</sup> *Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981). The Massachusetts Supreme Judicial Court found that there was a protected liberty interest in deciding whether or not to submit to antipsychotic drugs and held that that interest could be overridden only by an overwhelming state interest. *Id.* at 51 & n.9.

<sup>55</sup> *Mills*, 457 U.S. at 300-06.

<sup>56</sup> See *id.* at 306.

<sup>57</sup> See *Rogers v. Comm'r of Dep't of Mental Health*, 458 N.E.2d 308, 310 (Mass. 1983).

<sup>58</sup> The state court declared that competency decisions were within the province of judicial decision-makers rather than medical decision-makers. See *id.*

<sup>59</sup> See *id.*

<sup>60</sup> See *id.* at 316.

<sup>61</sup> See *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 97-106 (1984).

Accordingly, the First Circuit merely outlined the state substantive and procedural rights as enunciated in *Roe* and then concluded that those state rights rose above the federal constitutional floor.<sup>62</sup> Because the state rights were higher, there was little utility, the court said, in identifying and compelling adherence to the lower set of federal constitutional standards.<sup>63</sup>

Thus, after convoluted litigation paths, the *Rennie* court found a “qualified” right to refuse treatment for the involuntarily institutionalized mentally ill and the *Rogers* court made no assessment of the federal constitutional right, having found that Massachusetts standards exceeded federal standards.<sup>64</sup> Notwithstanding this flurry of activity between the U.S. Supreme Court and the two courts of appeals in the early 1980s, the Court ultimately provided no clear answer to the explicit question whether a person who has been involuntarily civilly committed has a constitutional right to refuse treatment with antipsychotic drugs.

Other state and federal lower courts have since joined the Courts of Appeals for the First and Third Circuits in determining that there is a right to refuse forced treatment with antipsychotic drugs.<sup>65</sup> Although due process is the usual basis, some courts have used other grounds. In *State ex rel. Jones v. Gerhardstein*,<sup>66</sup> for instance, the Wisconsin Supreme Court declined to reach the due process issue after it found a violation of equal protection.<sup>67</sup> The court found “beyond a reasonable doubt an irrational disparity of rights” afforded to persons involuntarily committed.<sup>68</sup> This disparity, which yielded the equal protection violation, occurred because pre-trial detainees in the criminal system retained a right to informed consent, whereas civilly committed persons did not.<sup>69</sup> In general, although the right to refuse psychiatric treatment is now clear, there is still much debate around its edges, specifically regarding the questions of when and how it can be overridden.<sup>70</sup>

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<sup>62</sup> See *Rogers v. Okin*, 738 F.2d 1, 6-9 (1st Cir. 1987).

<sup>63</sup> See *id.* at 9.

<sup>64</sup> For a comprehensive discussion of the *Rennie* and *Rogers* cases, see Brooks, *supra* note 27, at 939-63.

<sup>65</sup> See, e.g., *Jurasek v. Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883 (Wis. 1987).

<sup>66</sup> *Jones*, 416 N.W.2d at 883.

<sup>67</sup> See *id.* at 892-93.

<sup>68</sup> *Id.*

<sup>69</sup> See *id.*

<sup>70</sup> Even if a court acknowledges the right, that does not necessarily mean a victory for the mentally ill person. In *Jurasek v. Utah State Hospital*, the court upheld summary judgment in favor of the hospital in the face of due process

While avoiding pronouncements on the specific issue, the Supreme Court has issued opinions in several other cases concerning persons with mental illness that have shed light on its views. There is clearly a substantial liberty interest in avoiding commitment to a mental institution.<sup>71</sup> Furthermore, there is a right to be free of the unwarranted and stigmatizing effects of being labeled mentally ill, even if one has already been branded a criminal.<sup>72</sup> And there is a significant due process liberty interest in escaping the forced administration of antipsychotic drugs in the criminal justice arena.<sup>73</sup>

### 3. *The Right to Refuse Treatment in Penal Institutions*

The U.S. Supreme Court has twice spoken clearly about the right to refuse psychiatric treatment in penal settings. In *Washington v. Harper*,<sup>74</sup> the Court declared that a prisoner has the right to be free from the forced administration of unwanted drugs.<sup>75</sup> The *Harper* Court differed from other court decisions as to the basis of the right, however; it is grounded, wrote Justice Kennedy, in a Fourteenth Amendment liberty interest,<sup>76</sup> not in a constitutional right of privacy, as other courts have found.<sup>77</sup>

Although *Harper* established that there is a constitutionally protected liberty interest in refusing psychotropic medication in penal settings, the actual holding was a defeat for the inmate who had brought suit. Walter Harper, the plaintiff, was convicted of robbery and, after sentencing, was placed in the mental health unit of the prison where he voluntarily received antipsychotic drugs.<sup>78</sup> After Harper was paroled, he assaulted two nurses at a hospital and subsequently had his parole revoked. Once more he consented to medication prescribed for his manic depression.<sup>79</sup> Harper then

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violation claims. *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 509 (10th Cir. 1998). Central to the court's holding was a finding during the commitment proceeding that the patient was unable to make rational treatment decisions and was, therefore, according to the court, incompetent. *See id.* at 513.

<sup>71</sup> *See Addington v. Texas*, 441 U.S. 418, 425 (1979).

<sup>72</sup> *See Vitek v. Jones*, 445 U.S. 480, 487-94 (1980).

<sup>73</sup> *See Riggins v. Nevada*, 504 U.S. 127 (1992); *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>74</sup> *Harper*, 494 U.S. at 210.

<sup>75</sup> *See id.* at 219-27.

<sup>76</sup> *See id.* at 221-22.

<sup>77</sup> *See Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983).

<sup>78</sup> *See Harper*, 494 U.S. at 213-14.

<sup>79</sup> *See id.* at 214.

withdrew his consent, however, and the prison sought to force medication upon him in accordance with prison policy.<sup>80</sup> The policy recognized substantive and procedural rights for inmates who objected to treatment with antipsychotic drugs, but Harper took issue with particulars of the policy, asserting that he was entitled to a judicial hearing to determine whether he could be forcibly medicated against his will.<sup>81</sup> The Washington Supreme Court agreed, holding that “a competent, nonconsenting inmate” was entitled to a judicial hearing with “the full panoply of adversarial procedural protections” and that to override an inmate’s wishes, the state was required to establish by “‘clear, cogent, and convincing’ evidence that the administration of antipsychotic medication was both necessary and effective for furthering a compelling state interest.”<sup>82</sup>

The U.S. Supreme Court reversed the holding, however, finding that the state policy of affording only an administrative hearing was sufficient to satisfy Harper’s constitutional rights.<sup>83</sup> Although there was “no doubt,” the Court declared, that an inmate possesses a protected liberty interest in preventing the forced administration of antipsychotic drugs,<sup>84</sup> due process requires a neutral factfinder, not a judicial one.<sup>85</sup> Further, the Court suggested that an inmate’s medical needs might be better served by having the decision made by medical professionals.<sup>86</sup> The Court then declared that a lay advocate “who understands the psychiatric issues involved is sufficient” to protect the inmate’s interests, thereby rejecting the Washington Supreme Court’s mandate of counsel.<sup>87</sup>

The Court also explicitly rejected Harper’s contention that his right to refuse could be overridden only if he were found incompetent.<sup>88</sup> Linking the breadth of his right to his confinement, the Court stated that Harper’s

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<sup>80</sup> *See id.*

<sup>81</sup> *See id.* at 215-17. The policy provided for administrative hearings. *See id.* at 215-16. Harper made further arguments based on free speech principles, but that argument was not considered by either the Washington Supreme Court or the U.S. Supreme Court. *See id.* at 218 n.5. Arguments against forced treatment with antipsychotic medications occasionally raise the free speech argument, on the theory that permitting the government to alter one’s thinking process, a clear outcome of antipsychotic medications, violates First Amendment rights.

<sup>82</sup> *Id.* at 218.

<sup>83</sup> *Id.* at 228.

<sup>84</sup> *Id.* at 221-22.

<sup>85</sup> *See id.* at 231.

<sup>86</sup> *See id.* at 231-32.

<sup>87</sup> *Id.* at 236.

<sup>88</sup> *Id.* at 222.

due process rights were met by state policy that authorized forced medication only if a mental disorder existed that, if untreated, would cause harm, and that required medication was prescribed by a psychiatrist and sanctioned by a second reviewing psychiatrist.<sup>89</sup>

The *Harper* holding is simultaneously broad and narrow. First, it establishes that the right to refuse treatment is powerful enough to apply even to those who are deprived of their physical liberty.<sup>90</sup> Its broad scope may be likened to the holding in *Cruzan v. Director, Missouri Department of Health*,<sup>91</sup> where the Court declared that the right to refuse treatment is powerful enough to apply even to those who lack competence.<sup>92</sup> Thus, although the right might be qualified, it applies initially to a vast population, including the incarcerated and the incompetent.

Second, the prison setting of *Harper* also explains the Court's chary interpretation of the depth of the right. The Court held that a prisoner had a due process right to refuse forced psychotropic drugs but that the extent of this right "must be defined in the context of the inmate's confinement."<sup>93</sup> Governmental interest is always elevated in the prison setting and *Harper* established that a prisoner's right to refuse could be overcome by a legitimate penological interest.<sup>94</sup> In reaching this conclusion, the Court rejected the Washington Supreme Court's determination that in order to forcibly administer mind-altering drugs, a court must find that such drugs are necessary and effective to achieve a compelling state interest.<sup>95</sup> The

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<sup>89</sup> See *id.* at 221-23.

<sup>90</sup> The Eighth Amendment would, of course, prohibit cruel and unusual punishment in the prison setting, but *Harper* applies to compelled medication for the purpose of treatment, not punishment. See *id.*

<sup>91</sup> *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

<sup>92</sup> *Id.* at 279. It is important to remember that in *Cruzan* the Court *assumed*, but did not *decide*, that there was a right to refuse treatment. *Id.*

<sup>93</sup> *Harper*, 494 U.S. at 222.

<sup>94</sup> See *id.* at 223-24. The *Harper* reasoning has been used outside the prison setting. In *Jurasek v. Utah State Hospital*, the court found that the *Harper* analysis applied in the civil commitment setting and authorized forcible medication if a civilly committed patient is "incompetent to make medical decisions if the patient is dangerous to himself or others and the treatment is in the patient's medical interests." *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 511 (10th Cir. 1998). *Jurasek* also extended *Harper* by applying it to a person who is not a danger to self or others but who is gravely disabled. *Id.* at 512. The *Jurasek* court, however, required a finding of incompetence, something that *Harper* specifically rejected. *Harper*, 494 U.S. at 222; *Jurasek*, 158 F.3d at 511.

<sup>95</sup> See *Harper*, 494 U.S. at 220-23.

Court declared that such a rewriting of the substantive standard was not required by the Due Process Clause or the rights conferred by the state policy.<sup>96</sup> This conclusion appears to be based largely on the fact of confinement. Accordingly, although it is notable that Harper was afforded the right to refuse psychiatric treatment, the correctional setting of the case places clear limitations on the scope of this right.<sup>97</sup>

The *Harper* conclusion was reinforced in *Riggins v. Nevada*,<sup>98</sup> where the U.S. Supreme Court declared that the forcible administration of antipsychotic medication was constitutionally forbidden absent the state showing both the need for and the appropriateness of the drug at issue.<sup>99</sup> The Court reiterated that due process liberty interests were involved, stating that the interference with liberty worked by forced antipsychotic medication was "particularly severe."<sup>100</sup> In making this determination, the Court cited the numerous and dramatic side effects that may well accompany the benefits of antipsychotic drugs.<sup>101</sup> Those side effects include acute dystonia (a severe involuntary spasm of the upper body), akathisia (motor restlessness), neuroleptic malignant syndrome, and tardive dyskinesia (a frequently irreversible neurological disorder causing uncontrollable movement).<sup>102</sup>

In *Riggins*, David Riggins was found competent to stand trial on charges of robbery and murder.<sup>103</sup> He then sought a court order permitting him to cease his treatment with the antipsychotic drug Mellaril.<sup>104</sup> This request was denied, and Riggins was tried and convicted.<sup>105</sup> On appeal, he

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<sup>96</sup> See *id.* at 220-22 (rejecting the Washington Supreme Court's imposition of a requirement that the state show a compelling interest and adopting instead a standard requiring a mere finding, pursuant to the state prison policy, that the "inmate is 'gravely disabled' or that he presents a 'serious likelihood of harm to himself or others'").

<sup>97</sup> "[P]rison regulations alleged to infringe constitutional rights are judged under a 'reasonableness' test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights." *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 349 (1987). "[W]hen a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Turner v. Safley*, 482 U.S. 78, 89 (1987).

<sup>98</sup> *Riggins v. Nevada*, 504 U.S. 127 (1992).

<sup>99</sup> *Id.* at 135.

<sup>100</sup> *Id.* at 134.

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.* at 129-30.

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* at 131.



argued that this forced treatment violated numerous constitutional rights, including due process liberty interests.<sup>106</sup> The Nevada Supreme Court upheld his conviction.<sup>107</sup>

In its order reversing and remanding, the U.S. Supreme Court noted that the brevity of the trial court order denying Riggins's request to be taken off medication precluded an assessment of whether *Harper's* requirement of an overriding justification and finding of medical appropriateness prior to the forced administration of drugs had been met.<sup>108</sup> In comparing the case with *Harper*, the Court noted that a pre-trial detainee enjoys at least as much Fourteenth Amendment liberty protection as does a convicted prisoner.<sup>109</sup>

The U.S. Supreme Court has made it clear that there is a constitutionally protected liberty interest in refusing unwanted medication or treatment, including psychiatric medication. This interest extends to the criminally involved, in both the pre-trial<sup>110</sup> and post-trial phases.<sup>111</sup> It also embraces persons who are incompetent.<sup>112</sup> It is the combination of these two principles—the right to refuse psychiatric treatment and the right to have that refusal honored during periods of incompetence, through the instrument of an advance directive—that is examined next.

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<sup>106</sup> *Id.* at 131-32. Although this case involved, by its most literal terms, synthetic competence, it did not present the issue of whether a defendant rendered competent through drugs has the right to cease taking drugs, thus becoming incompetent and untriable. *Id.* at 136. Justice Kennedy, however, took on this issue with vigor in his concurrence. See *id.* at 138-45 (Kennedy, J., concurring). Justice Kennedy stated that it was his view that "absent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial." *Id.* at 139 (Kennedy, J., concurring).

<sup>107</sup> *Id.* at 132.

<sup>108</sup> *Id.* at 138.

<sup>109</sup> *Id.* at 135.

<sup>110</sup> See *Riggins*, 504 U.S. at 127.

<sup>111</sup> See *Washington v. Harper*, 494 U.S. 210 (1990). It is reassuring to note that lower courts since *Harper* and *Riggins* have not merely rubber-stamped administrative findings of medical appropriateness and safety. See, for example, *United States v. Weston*, 206 F.3d 9 (D.C. Cir. 2000) (per curiam), in which the court of appeals reversed and remanded a district court's approval of a forced medication decision made by the Bureau of Prisons. *Id.* at 10-11. Reversal was required because the district court finding that the medication was "not only medically appropriate but also essential to safety" was not supported by the record. *Id.* at 13.

<sup>112</sup> See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

## III. ADVANCE DIRECTIVES

## A. Primer

An advance directive is a means by which a competent person leaves instructions regarding what medical treatment that person wants or does not want, should the person later become incompetent. Using principles of agency law, the person executing the advance directive—the principal—gives legal authority to a third person—the agent—to make decisions regarding the principal's health. The concept of advance directives has existed for decades,<sup>113</sup> often under the name of a living will.<sup>114</sup> Early proposals for psychiatric or mental health advance directives also date back decades.

Advance directives garnered new attention after *Cruzan v. Director, Missouri Department of Health*,<sup>115</sup> where the value of having an incompetent person's wishes clearly stated before incompetency occurred was underscored in a sad and dramatic way. The U.S. Supreme Court recognized, presumptively,<sup>116</sup> the constitutionally protected right to refuse treatment, but upheld a state's right to require that the exercise of that right be proven by clear and convincing evidence.<sup>117</sup> The Court reached this conclusion by balancing the individual and state interests involved.<sup>118</sup> Also, the *Cruzan* decision illustrated the importance of creating written instructions by noting that a written document is more likely than an oral statement to satisfy a clear and convincing standard.<sup>119</sup>

Before discussing advance directives, a threshold question must be resolved: does the universally recognized<sup>120</sup> right to refuse treatment cover

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<sup>113</sup> In an article written just a year before *Cruzan*, Professor Nancy Rhoden argued cogently for acceptance of "prior directives" or "living wills" (the phrase "advance directive" was not yet in the lexicon). See Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845, 860 (1990).

<sup>114</sup> The term "living will" is still used today to refer to instructional directives. For a discussion of instructional versus proxy directives, see *infra* Part III.C.1-2.

<sup>115</sup> *Cruzan*, 497 U.S. at 261.

<sup>116</sup> *Id.* at 279.

<sup>117</sup> *Id.* at 284.

<sup>118</sup> See *id.* at 279-84.

<sup>119</sup> This is not to say, however, that advance directives are always followed. At times, this may be warranted, based on concerns about the validity of the particular instrument. On other occasions, it may be that others—family members or medical personnel—disagree with the document and thus refuse to give it its proper due.

<sup>120</sup> Although universally recognized, the right is not absolute. It can be abridged for reasons of societal danger and needs of dependent third parties. See ALLEN E.

future as well as contemporaneous treatment? While the weight of opinion is that a validly executed advance directive has the equivalent moral and legal force as a current treatment consent or refusal, a few commentators posit otherwise. Rebecca Dresser states that "future-oriented treatment decisions cannot be equated with the active choices of competent patients."<sup>121</sup> She argues that advance directives lack the on going dialogue, current information, and patient input at the critical moment.<sup>122</sup> Allen Buchanan and Dan Brock state that because competent persons are not as good a judge of future situations as they are of the present, and because there are fewer procedural safeguards for future decision-making, advance directives do not rise to the level of a contemporaneous choice.<sup>123</sup>

Another concern raised about the validity of honoring advance directives is that, in essence, two different persons are involved, the competent person who executed the advance directive and the subsequently incompetent person who is subject to it.<sup>124</sup> Under this concept of personal identity,<sup>125</sup> permitting the past "self" to dictate treatment to the present "self" is paternalistic and, therefore, the advance directive loses its moral and legal force of self-determination and autonomy.<sup>126</sup>

While it is undeniably true that persons evolve, that illness alters, and that mental illness may alter above all else, the personal identity formulation is problematic. Even if the person in question is in some very real sense a different "self" from the person who executed the directive, that prior "self" is still the most logical, least paternalistic person to dictate

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BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 110 (1989); Rebecca S. Dresser, *Advance Directives, Self-Determination, and Personal Identity*, in *ADVANCE DIRECTIVES IN MEDICINE* 155, 156 (Chris Hackler et al. eds., 1989).

<sup>121</sup> Dresser, *supra* note 120, at 157.

<sup>122</sup> *Id.*

<sup>123</sup> See BUCHANAN & BROCK, *supra* note 120, at 105-07.

<sup>124</sup> See generally Dresser, *supra* note 120, at 158. This theory is fully articulated by Derek Parfit, who suggests that there are two views of personal identity, the "Simple View" and the "Complex View." *Id.* Under the latter, if there is not "psychological continuity" between the current person and the prior person in areas such as memories, desires, and values, then there is no identity of self. See *id.* For a full discussion, see DEREK PARFIT, REASONS AND PERSONS 204-06 (1986) [hereinafter PARFIT, REASONS AND PERSONS]; Derek Parfit, *Later Selves and Moral Principles*, in *PHILOSOPHY AND PERSONAL RELATIONS* 137, 140 (A. Montefiore ed., 1973).

<sup>125</sup> See PARFIT, REASONS AND PERSONS, *supra* note 124, at 204-06.

<sup>126</sup> Dresser, *supra* note 120, at 160.

treatment for the present "self." As Professor Nancy Rhoden has said, a component of respecting persons is viewing them as they view themselves, which requires that their prior choices and values not be ignored.<sup>127</sup> Moreover, as Rhoden suggests, adopting the view that the incompetent "self" is not bound by the advance directive of the prior competent "self" "would wreak societal havoc."<sup>128</sup> Her observation that a "one body, one person" rule<sup>129</sup> is necessary for the functioning of civil and criminal law seems, in the words of the *Rogers* court, "an intuitively obvious proposition."<sup>130</sup> Further, the *Cruzan* decision assumed that the right to refuse treatment extends to persons during periods of incompetence.<sup>131</sup> This right has primary meaning in the context of future decisions.<sup>132</sup>

Advance directives, now variously known as proxy directives, advance instructions, instructional directives, or durable powers of attorney,<sup>133</sup> resolve the problem presented in *Cruzan*: they create a means by which persons can communicate choices for a prospective period of incompetence.

### B. *The Patient Self-Determination Act*

In 1990, Congress passed the Patient Self-Determination Act ("PSDA"),<sup>134</sup> in part as a response to the *Cruzan* decision. The act requires all health care facilities receiving Medicare or Medicaid to inform patients of their decision-making power under state law, including the right to

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<sup>127</sup> Rhoden, *supra* note 113, at 860.

<sup>128</sup> *Id.* at 854.

<sup>129</sup> *Id.*

<sup>130</sup> *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980).

<sup>131</sup> *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990).

<sup>132</sup> It is possible that the medical-treatment wishes of an incompetent person are *current* decisions. In some jurisdictions, treatment decisions for an incompetent person are assessed pursuant to the substituted judgment doctrine. Under this doctrine, a substituted judgment decision-maker makes treatment decisions for the incompetent person based upon what that decision-maker believes the incompetent person would decide if competent. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 429 (Mass. 1977). In making this decision, the substitute decision-maker could assess what the incompetent person would want presently, without being bound by a prior choice.

<sup>133</sup> There are other forms of advance directives, such as do-not-resuscitate orders and organ-donation instruments, that are not directly relevant here. See Lieberman, *supra* note 17, at 307-11.

<sup>134</sup> 42 U.S.C. § 1395cc (1994).

accept or refuse treatment.<sup>135</sup> Patients must also be given information regarding their right to execute advance directives.<sup>136</sup> Finally, patients must be asked, upon admission, if they have an advance directive.<sup>137</sup> Thus, the PSDA ensures that individuals be told of their rights, including advance directive statutes where they exist.<sup>138</sup>

The PSDA has been criticized for not achieving its goal of increasing the number of patients who have executed advance directives.<sup>139</sup> Some commentators, however, suggest that the PSDA has increased physicians' awareness of and respect for an individual's right to refuse treatment.<sup>140</sup>

The PSDA has several effects on mental health advance directives. First, the PSDA includes community mental health centers in its definition of partial hospitalization services to which the act applies.<sup>141</sup> Further, the PSDA requires notification to the patient of the right to refuse treatment as well as the relevant state law and the right to execute advance directives thereunder<sup>142</sup>—the type of treatment involved is not restricted by the terms of the statute or its regulations.<sup>143</sup> Therefore, if a particular state's advance directive law specifically includes mental health care, then the patient must be so informed.

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<sup>135</sup> *Id.* § 1395cc(f)(1)(A)(i).

<sup>136</sup> *Id.*

<sup>137</sup> *Id.* § 1395cc(f)(1)(B).

<sup>138</sup> All states now have some form of advance directive or health care proxy statute. Paul F. Stavis, *The Nexum: A Modest Proposal for Self-Guardianship by Contract, A System of Advance Directives and Surrogate Committees-At-Large for the Intermittently Mentally Ill*, 16 J.CONTEMP. HEALTH L. & POL'Y 1, 43 (1999).

<sup>139</sup> See generally Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997) (arguing that the use of advance directives will be limited and alternative methods of arriving at such medical decisions will be necessary).

<sup>140</sup> Lieberman, *supra* note 17, at 317-18.

[L]istening to the comments at the hospital Bioethics Committee for the last nine years, there is clearly a trend toward better appreciation of patient and family rights to make decisions in these matters by the hospital staff . . . . Certainly the PSDA does serve to bring the issue out of the legal office and into the hospital where it belongs.

*Id.* at 318.

<sup>141</sup> 42 U.S.C. § 1395cc(e)(2) (1994).

<sup>142</sup> *Id.* § 1395cc(f)(1)(A)(ii).

<sup>143</sup> 42 C.F.R. § 489.102 (1999).

In state advance directive statutes where mental health advance directives are not mentioned, however, what does the PSDA require? Until those statutes are tested in the courts, there is no dispositive answer.<sup>144</sup> Unless, however, the statute has language limiting the types of medical decisions specifically to terminal illness or vegetative state situations, even a generic durable power of attorney for health care ought to cover mental health care decisions and thus must be explained under the PSDA.

### *C. Advance Directives for Physical Illness*

#### *1. Instructional Directives*

The instructional directive is a document by which persons spell out what treatment they desire or refuse in the event that future incompetence precludes contemporaneous decision-making. It has certain drawbacks, however. An instructional directive can only dictate that certain procedures be followed or not; it is often a standard, fill-in-the-blanks form and lacks flexibility. These limitations have led to suggestions that it is the least preferable form of advance directives.<sup>145</sup> Further, people cannot accurately predict advances in health care or what course they will actually want followed in certain circumstances. When the time comes to act upon the instructional directive, circumstances and consequences may be wildly divergent from those existing or imagined at the time of the creation of the directive.<sup>146</sup> Even if circumstances are different, however, it is legally reasonable and morally appropriate to assume that the principal is more likely to hit the mark than are third parties interposing their beliefs or their guesses regarding the principal's beliefs and desires.

#### *2. Proxy Directives*

A proxy directive appoints another person<sup>147</sup> as a health care proxy, also known as an attorney-in-fact. The principal thereby delegates decision-

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<sup>144</sup> See JOHN PARRY, *MENTAL DISABILITY LAW: A PRIMER* 105 (5th ed. 1995). As of 1995, there was one case on point. See *In re Rosa M.*, 597 N.Y.S.2d 544 (N.Y. Sup. Ct. 1991); *infra* notes 303-12 and accompanying text.

<sup>145</sup> See Charles P. Sabatino, *Ten Legal Myths About Advance Medical Directives*, 28 CLEARINGHOUSE REV. 653, 653 (1994).

<sup>146</sup> Note, however, that some jurisdictions attempt to address this problem by permitting the instructional directive to provide consent to FDA approved drugs "approved and in existence after [the patient's] declaration and . . . in the same class as psychoactive medications as [indicated in the declaration]." See, e.g., TEX. CIV. PRAC. & REM. CODE ANN. § 137.011 (Vernon Supp. 2000).

<sup>147</sup> A secondary proxy may be appointed in the event the first proxy is unavailable.

making authority to a third party instead of committing such decisions to paper in the form of an instructional directive. The principal may also provide instructions for the proxy. At least one jurisdiction binds the proxy to make decisions "consistent with any desires the principal has expressed in the declaration."<sup>148</sup> This concept of health care proxies preceded the Patient Self-Determination Act by several years and was recommended in 1983 by the President's Commission for the Study of Ethical Problems in Medicine.<sup>149</sup>

All states and the District of Columbia have some form of statutory authority for advanced health care decisions.<sup>150</sup> Historically, a durable power of attorney, like a regular power of attorney, covers personal and financial decisions but, unlike a standard power of attorney, is effective during periods of a principal's incapacity. It was an easy step to include medical decision-making, and some states moved to amend their statutes accordingly. Several states have gone even further and have incorporated into their statutory scheme provisions for powers of attorney for mental health decisions.<sup>151</sup>

### 3. *Combination Directives*

A combination of an instructional directive with a proxy directive may be the most effective way to effectuate an individual's wishes.<sup>152</sup> The drawback of each type of directive is counterbalanced by the presence of the other. For instance, an instructional directive suffers from its inertness. Once written, it is likely to be forgotten and unmodified as advances in medical technology or changes in life views occur. Then, once needed when the principal becomes incompetent, it is legally impossible to modify it. The effect of combining an instructional directive with a proxy directive

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<sup>148</sup> OR. REV. STAT. § 127.705 (1999).

<sup>149</sup> Paul S. Appelbaum, *Advance Directives for Psychiatric Treatment*, 42 HOSP. & COMMUNITY PSYCHIATRY 983, 983 (1991).

<sup>150</sup> Robert D. Fleischer, *Advanced Directives for Mental Health Care: An Analysis of State Statutes*, 4 PSYCHOL. PUB. POL'Y & L. 788, 790 (1999).

<sup>151</sup> Such states include Hawaii, Illinois, Maine, Minnesota, North Carolina, and Oregon. See HAW. REV. STAT. § 327E-2 (Supp. 1999); 755 ILL. COMP. STAT. ANN. 45/4-4(b) (West 1993); ME. REV. STAT. ANN. tit. 18-A, § 5-802(i) (West Supp. 2000); MINN. STAT. ANN. § 145C.01(4) (West Supp. 2000); N.C. GEN. STAT. § 32A-19(a1) (1999); OR. REV. STAT. § 127.702(1) (1999).

<sup>152</sup> Sabatino, *supra* note 145, at 653 ("A . . . better alternative is to execute *both* documents or a single, combined Advance Directive that names a proxy *and* provides guidance about one's wishes.").

is that the proxy can modify the directive based on an understanding of the principal's wishes.<sup>153</sup> The very existence of a proxy can be helpful in ensuring that the instructional directive is honored by medical personnel.

A proxy directive alone, on the other hand, runs the risk that the proxy's wishes, not the principal's, will be effectuated. Accordingly, a proxy directive combined with an instructional directive enhances the likelihood that the proxy will act as a true agent and ensures that the will of the principal is observed.

#### 4. *Components of an Advance Directive*

It is important to define when an advance directive takes effect and when its authority ceases. Generally, advance directives spring into force only when the principal becomes incompetent. While still competent, the principal continues to make decisions.

Determining incompetence can be a vexing task.<sup>154</sup> A court declaration of incompetence, of course, is dispositive. Such determinations are not commonplace, however. Many state advance directive statutes confer upon the doctor the right to assess capacity, which in turn can lead to a determination of incompetence, although more than one doctor may be required to make the determination.<sup>155</sup> Other states also authorize a judge to make the competency determination.<sup>156</sup> Further complicating the determination, many state statutes use different terms to mean essentially the same thing. Competence, capacity, and "of sound mind" are all used in various statutes, and the varying terms add a layer of confusion.<sup>157</sup> Although courts vary in their assessment of competence, it is commonly understood to be a legal and not a medical decision.<sup>158</sup>

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<sup>153</sup> Such a modification would only be necessary if there were significantly different circumstances.

<sup>154</sup> Determining competence can be troubling in either physical or mental health advance directives. In some circumstances, however, the difference is apparent. No one doubts the incompetence of a person in a coma; there is room for debate, however, with respect to someone in psychiatric distress. See Scott J. Brown, *Advance Directives Move Into Mental Health Care*, CLINICAL PSYCHIATRY NEWS, July 1995, at 10, 11.

<sup>155</sup> See, e.g., OKLA. STAT. ANN. tit. 43A, § 11-110 (West Supp. 2000).

<sup>156</sup> See, e.g., OR. REV. STAT. § 127.700(5) (1999).

<sup>157</sup> See, e.g., FLA. STAT. ANN. § 765.101(8) (West Supp. 2001); MO. ANN. STAT. § 404.805(2) (West Supp. 2001); N.C. GEN. STAT. § 122C-72(1) (1999).

<sup>158</sup> See *supra* note 17. "[C]ompetency is not a medical decision and should not merge with the commitment decision." *In re K.K.B.*, 609 P.2d 747, 749 (Okla.



Further, a civil commitment is no longer equivalent to a determination of incompetence.<sup>159</sup> This has shifted over the past few decades, as rights for persons with mental illness have increased. Often, unfortunately, a shift in the laws is not always mirrored by a shift in public opinion. Indeed, little is required to establish incompetence in the eyes of many who still retain nineteenth century notions that persons with mental illness are per se incompetent.<sup>160</sup> Contrary to public opinion, however, only when there has been a discrete assessment of incompetence may the state legitimately exercise its *parens patriae* power.

Many statutes provide that an advance directive cannot take effect until it is placed in the principal's medical file or given to the appropriate health care professional.<sup>161</sup> In some states, however, an advance directive is effective when written.

When does an advance directive cease to be effective?<sup>162</sup> Obviously, when the principal regains competence. While the answer may be obvious, its application is less so. For end-of-life advance directives, competence may never be regained and such a question never reached. Mental health

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1980).

<sup>159</sup> See, e.g., CAL. WELF. & INST. CODE § 5331 (West 1998); State *ex rel.* Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987). Nor does a commitment decision necessarily strip the committed person of the right to refuse medication. See, e.g., CAL. WELF. & INST. CODE § 5326.5(d) (West 1998).

<sup>160</sup> Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCH. PUB. POL'Y & L. 137, 151 (1996) ("In the 19th century, mental illness was regarded as an illness with certain characteristic effects. Among them was that mental illness invariably destroyed decision-making ability.").

<sup>161</sup> See, e.g., OR. REV. STAT. § 127.710 (1999). This requirement may create an additional barrier to the use of mental health advance directives. Someone in the throes of a mental health crisis may well end up in any manner of places, and end up there without a copy of her advance directive handy. See Patricia Backlar, *Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning for End-of-Life Care*, 33 COMMUNITY MENTAL HEALTH J. 261, 266 (1997). Accordingly, Backlar suggests that a central registry may be called for, provided it is enacted with provisions that protect confidentiality. *Id.* Another alternative is to have an emergency card that a person can carry in a wallet. Deborah S. Pinkney, *Advance Directive Could Give Mentally Ill More Treatment Control*, AM. MED. NEWS, Dec. 16, 1991, at 3, 22. These cards, already in use in Hawaii, could list the existence and site of a person's mental health advance directive. See *id.*

<sup>162</sup> A principal can revoke or rescind an advance directive, but such revocation would usually occur while competent. Some states also provide for time limits on advance directives. See, e.g., UTAH CODE ANN. § 62A-12-502(6)(a) (2000).

advance directives, on the other hand, address cyclical illnesses and the issue of regaining competence is likely to arise.

#### *D. Mental Health Advance Directives*

##### *1. Early Development*

Advance directives for physical health decisions have arrived as a legal concept.<sup>163</sup> Mental health advance directives, although not yet fully embraced, have been under consideration for decades.<sup>164</sup> As with physical health advance directives, mental health advance directives come under various names, including living wills,<sup>165</sup> Ulysses contracts,<sup>166</sup> psychiatric wills,<sup>167</sup> and voluntary commitment contracts.<sup>168</sup> The terminology "advance directive" gained currency in the 1990s.

The Ulysses contract is a very particular kind of mental health advance directive by which persons consent to treatment during periods of future incompetence.<sup>169</sup> The key to the Ulysses contract, and the reason for its

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<sup>163</sup> Whether or not they are followed is another issue. See, for example, Backlar, *supra* note 161, at 262, for a list of studies that have found that advance directives are disregarded. See generally Gary N. Sales, *The Health Care Proxy for Mental Illness: Can It Work and Should We Want It To?*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 161, 163-65 (1993) (discussing patient and doctor attitudes towards and experiences with advance directives).

<sup>164</sup> Mental health advance directives have been debated for some years now. In 1991, Paul Appelbaum suggested that mental health advance directives were "on the verge of having a major impact on psychiatric care." Appelbaum, *supra* note 149, at 983. Allen Buchanan and Dan Brock referred to mental health advance directives in 1989, as "an important . . . but . . . largely untapped . . . opportunity." BUCHANAN & BROCK, *supra* note 120, at 350.

<sup>165</sup> BRUCE J. ENNIS & RICHARD D. EMERY, *THE RIGHTS OF MENTAL PATIENTS* 43 (1978).

<sup>166</sup> JON ELSTER, *ULYSSES AND THE SIRENS* (1979).

<sup>167</sup> Szasz, *supra* note 6, at 762.

<sup>168</sup> Dresser, *supra* note 6, at 777-78. This article is an early offering in the field. Dresser, however, critiques voluntary commitment contracts, rather than praises them. She finds their paternalism, albeit self-paternalism, fraught with problems. See *id.* at 785.

<sup>169</sup> See Audrey Macklin, *Bound to Freedom: The Ulysses Contract and the Psychiatric Will*, 45 U. TORONTO FAC. L. REV. 37 (1987), for a discussion of the difference between refusing and consenting to treatment in an advance directive.

name,<sup>170</sup> is its irrevocability. No matter how much subsequently incompetent consumers<sup>171</sup> plead to change what is in the contract, such pleas are not to be heeded.<sup>172</sup> The belief is that while competent, persons can clearly select that which is best, a choice that they might rescind when incompetent and in the throes of a mental illness.<sup>173</sup>

The notion of irrevocability during periods of incompetence is nothing new; indeed, it is standard legal doctrine to require competence before any legally binding decision is made. Different here, however, is that some commentators have suggested that a Ulysses contract should be irrevocable even during periods of future competence.<sup>174</sup> On the other hand, some durable power of attorney statutes provide for revocation regardless of a principal's mental state.<sup>175</sup> This idea, that a patient's subsequent decision should always supersede a prior advance directive, especially if it chooses treatment formerly refused, finds support in numerous quarters.<sup>176</sup>

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<sup>170</sup> The name refers to Ulysses's instruction to his crew to tie him to the ship's mast and leave him bound as the ship approached the Sirens, regardless of his subsequent entreaties to cut him loose. *See* HOMER, *THE ODYSSEY* 258-59 (William Cullen Bryant trans., 1899).

<sup>171</sup> It is now commonplace within the field to refer to users of mental health services as consumers, not patients or clients, although those terms may still be appropriate in certain circumstances.

<sup>172</sup> Unlike a traditional advance directive, which is unilateral, a Ulysses contract is a contract between patient and doctor. Macklin, *supra* note 169, at 38. There are now different variations on the theme of Ulysses contracts. The terms most likely to change are those regarding whether the irrevocability applies to periods of competence as well as incompetence and whether one can reject as well as consent to treatment via the contract. The term has also been altered to include Ulysses directives, defined to mean a Ulysses contract authorized by statute. *See* Roberto Cuca, Note, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute*, 78 CORNELL L. REV. 1152, 1154 (1993).

<sup>173</sup> *See* Jennifer Radden, *Planning for Mental Disorder: Buchanan and Brock on Advance Directives in Psychiatry*, 18 SOC. THEORY & PRAC. 165, 169-72 (1992); Rhoden, *supra* note 113, at 853.

<sup>174</sup> *See* Winick, *supra* note 6, at 86-94. Certainly, however, some commentators support revocability of Ulysses contracts by competent persons. *See* Radden, *supra* note 173, at 179; Cuca, *supra* note 172, at 1174.

<sup>175</sup> *See, e.g.,* ARIZ. REV. STAT. ANN. § 36-3285(A) (West Supp. 2000); UNIF. HEALTH-CARE DECISIONS ACT § 3(b), 9 (I.B) U.L.A. 155 (1999) ("An individual may revoke . . . an advance health-care directive . . . at any time and in any manner that communicates an intent to revoke."); Stavis, *supra* note 138, at 43 & n.137.

<sup>176</sup> *See* ARIZ. REV. STAT. ANN. § 36-3285(A) (West Supp. 2000); Dresser, *supra* note 6, at 782-83; Elizabeth M. Gallagher, *Advance Directives for Psychiatric*

Two different principles are at work here under the concept of autonomy. Those principles are seen in the juxtaposition of choosing future treatment and in rejecting it. When individuals choose to bind themselves, like Ulysses, to treatment in the future when they fear their resolve will be weak, they ostensibly choose better judgment over moral weakness.<sup>177</sup> They know what is right as it is seen clearly in the present, but fear the inability to claim that right path at some future point. Although some have asserted that this is paternalistic, it is nonetheless justifiable on autonomy principles.

On the other hand, when the right to refuse treatment is asserted in an advance directive, also under the rubric of self-determination, some would argue that such a position is morally irresponsible. That argument suggests that the counterpoint of autonomy is responsibility and that refusing treatment—and thereby arguably prolonging illness—is irresponsible. It is clear that the right to refuse is a qualified right that may be overridden when, for instance, dependent third parties are involved.<sup>178</sup> Some would take the responsibility principle further and assert an obligation to make “healthful decisions.”<sup>179</sup> To apply this theory, however, to those with mental illness would be discriminatory and would invite charges of sanism,<sup>180</sup> for one simple reason: “healthful decision[-making]” is not required of persons who are not mentally ill.

Dr. Thomas Szasz suggests the use of a psychiatric will to achieve the goal of complete protection from coerced psychiatry without depriving persons who wish to be the beneficiaries of involuntary psychiatric interventions from the protections that such measures “allegedly” offer.<sup>181</sup> Szasz suggests that, with a psychiatric will, persons could avoid involuntary psychiatric care should they become acutely ill and unable to competently reject treatment.<sup>182</sup> He proposes an inverted psychiatric will,

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*Care: A Theoretical and Practical Overview for Legal Professionals*, 4 PSYCHOL. PUB. POL’Y & L. 746, 778-82 (1998).

<sup>177</sup> See Radden, *supra* note 173, at 175.

<sup>178</sup> *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985); cf. Randy Cohen, *Worse for Not Wearing*, N.Y. TIMES, May 21, 2000, § 6 (Magazine), at 18.

<sup>179</sup> Stavis, *supra* note 138, at 47.

<sup>180</sup> See *infra* note 361 and accompanying text.

<sup>181</sup> See Szasz, *supra* note 6, at 763. In view of Szasz’s position that mental illness does not exist, this proposal provides for autonomy unconditionally in that it allows a person to opt for treatment for what is, in Szasz’s eyes, a non-existent illness. See *id.* at 767-68. Its medical soundness is another matter.

<sup>182</sup> See *id.* at 766. The will analogy has been used by others. Professor Winick has even suggested that, in cases where an advance directive cannot be followed

in which persons who wanted treatment would execute such a will; the absence of a psychiatric will would signify a lack of consent.<sup>183</sup> He concedes, however, that current social practice makes such an arrangement impracticable.<sup>184</sup> He therefore suggests a document in which persons would forbid their confinement to a mental hospital.<sup>185</sup>

The voluntary commitment contract springs into effect not upon the consumer's incompetence, but rather, upon the consumer's deterioration to the point where medication and treatment would be beneficial.<sup>186</sup> One could argue that this concept short-circuits self-determination by removing decision-making power before incompetence occurs. If it is indeed a voluntary choice, however, a voluntary commitment contract gives voice to autonomy of a different kind. There is undoubtedly a netherworld of quasi-competence. If persons know that they inhabit that world, they may well choose to cede certain rights of self-determination for other benefits.<sup>187</sup> Therefore, a voluntary commitment contract honors a person's right to bring into effect choices sooner than the law would permit absent explicit instructions.

## 2. *Current Development*

The Supreme Court has not ruled directly on the validity of advance directives for mental illness. All of its various pronouncements related to the concept suggest only that the Court would embrace the validity of mental health advance directives if the issue were to come before it.<sup>188</sup> The

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precisely as the principal intended, it should be reinterpreted in a way consistent with the principal's will, thus creating an advance directive version of the cy pres doctrine, which permits terms of a will to be recast to permit compliance with a testator's intent. *See* Winick, *supra* note 6, at 90-91.

<sup>183</sup> *See* Szasz, *supra* note 6, at 768.

<sup>184</sup> *See id.* at 768-69.

<sup>185</sup> *See id.* at 768. It is unlikely that such a proscription would be honored under certain circumstances. A person's danger to others (and perhaps self) might be sufficient to invoke the state's police or *parens patriae* power to override a decree not to be involuntarily committed. However, if a person forbade the use of psychiatric medications—as opposed to hospitalization—a stronger argument could be made for adhering to the will, as there might be alternate ways such as confinement to satisfy the state's interest in protecting others.

<sup>186</sup> *See* Dresser, *supra* note 6, at 777-83.

<sup>187</sup> This concept has been criticized as being a form of self-paternalism. *See id.* at 784-87.

<sup>188</sup> *See* Winick, *supra* note 6, at 64. Professor Winick asserts that the due process liberty interest recognized in *Cruzan* applies to all "persons," including the

Court has repeatedly upheld the doctrines of autonomy and self-determination. It has extended the right to refuse treatment to the incompetent<sup>189</sup> and to issues involving psychiatric medication.<sup>190</sup> Indeed, the extension of advance directives to mental health may be easier than the initial adoption of directives for physical health care, as several of the key state interests against which a refusal of life-sustaining treatment must be weighed are absent in mental health cases. For example, the state's interest in saving a particular individual's life and in preserving the sanctity of life are not typically issues in psychiatric care.<sup>191</sup>

There are differences between advance directives for mental health care and physical health care. There are, however, many similarities; they are, at the core, the same document.<sup>192</sup> Any kind of advance directive addresses future situations and attempts to anticipate the decisions that those situations will require. With a mental health advance directive, individuals think about prospective choices regarding their mental health care. They set forth instructions regarding mental health care that are to take effect during future periods of incompetence.<sup>193</sup> As with a physical health care advance directive, a mental health advance directive may be either an instructional directive, a proxy directive,<sup>194</sup> or a combination of the two. As with a

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mentally ill, pursuant to the Fifth and Fourteenth Amendments. *Id.* at 67. The right of the mentally ill to refuse treatment was recognized by the U.S. Supreme Court in *Riggins v. Nevada* and *Washington v. Harper*. *Riggins v. Nevada*, 504 U.S. 127 (1992); *Washington v. Harper*, 494 U.S. 210 (1990). In those cases, however, the Court was not required to examine the advance planning concept as it related to mental health issues.

<sup>189</sup> See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

<sup>190</sup> See *Riggins*, 504 U.S. at 127; *Harper*, 494 U.S. at 210.

<sup>191</sup> Of course, a refusal of treatment could potentially cause a rapid deterioration into a psychotic state or place a person at heightened risk for causing injury to others. In those circumstances, other state interests might come in to play. For a discussion of when a state's police or parens patriae powers might override an advance directive for psychiatric care, see *infra* Part III.D.3.

<sup>192</sup> *Contra* Patricia Backlar, *Anticipatory Planning for Research Participants with Psychotic Disorders Like Schizophrenia*, 4 PSYCHOL. PUB. POL'Y & L. 829, 839-40 (1998); Radden, *supra* note 173, at 171-72.

<sup>193</sup> Although advance directives, whether for physical or psychiatric care, take effect upon incompetence, a voluntary commitment contract may be available to take effect during that period where incompetence cannot be established but the person may be suffering the ill effects of mental illness nonetheless. See Dresser, *supra* note 6, at 777-83.

<sup>194</sup> Patricia Backlar has pointed out that for some individuals with severe and persistent mental illness, relationships with close friends and family, those whom

physical health care advance directive, a mental health advance directive could either reject treatment or consent to it.<sup>195</sup> For each type of directive, the individual must be competent when executing the directive and must comply with any statutory requirements.<sup>196</sup> Advance directive statutes are legislative embodiments of constitutional and common law rights. Thus, even if an advance directive did not meet particular statutory provisions, it would nonetheless prove useful as a clear statement of a person's wishes which, under constitutional and common law principles, should be honored.

Despite the similarities, there are numerous distinctions between advance directives for physical health care and mental health advance directives. The first is the nature of the decision made. As one author has stated: "one directive attempts to guarantee . . . a good death; while the other endeavors to secure . . . a good life."<sup>197</sup> In a typical advance directive for physical health care, one is projecting choices for future circumstances involving terminal medical decisions.<sup>198</sup> These circumstances, although potentially prolonged and doubtless trying, happen only once. Psychiatric disorders, on the other hand, are typically cyclical and, accordingly, address behavior that is familiar and predictable.<sup>199</sup> Consequently, persons executing advance directives for end-of-life decisions can only speculate about what they would want, whereas those with mental illness executing

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one might naturally seek as a proxy, are often fractured beyond repair, or at least beyond the point where a proxy selection would be appropriate. Backlar, *supra* note 161, at 264. On the other hand, mental health providers, who in some circumstances form close relationships with mental health consumers, cannot be chosen as a proxy because of the obvious conflict of interest. *Id.* It has also been suggested that a mental health consumer's distrust of others makes proxy directives more difficult in the psychiatric arena. *See* Brown, *supra* note 154, at 10.

<sup>195</sup> In the mental health area, consenting to treatment is potentially more legally troublesome than is refusal of treatment, as there is not yet a constitutionally established right to treatment. This legal wrinkle may run contrary to popular opinion, which may likely be more troubled by an advance directive that refuses antipsychotic drugs than one that consents to them. The right to treatment, although not constitutionalized, has been recognized by numerous courts. *See* Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 ST. LOUIS U. L.J. 315, 320-23 (1996).

<sup>196</sup> These statutory requirements could include, for example, executing an advance directive in the presence of witnesses. *See, e.g.,* D.C. CODE ANN. § 21-2205(c) (Supp. 2000).

<sup>197</sup> Backlar, *supra* note 161, at 262.

<sup>198</sup> *Id.*

<sup>199</sup> Backlar, *supra* note 192, at 840.

mental health advance directives may well have already experienced the condition about which they are seeking to make future decisions.<sup>200</sup> In such circumstances, mental health advance directives make even more sense.

Second, mental health advance directives may have different and potentially greater long-term consequences for both the individual and society. For instance, an advance directive articulating the right to refuse treatment will, in physical health care cases, most likely accelerate death.<sup>201</sup> By contrast, refusal of treatment via a mental health advance directive may not hasten death in any measurable sense, but may well have other quantifiably negative consequences. For example, when persons with mental illness deteriorate into psychosis, they, upon emerging from the psychotic state, likely are less well than before: their baseline functioning level is diminished as a result of having been psychotic.<sup>202</sup> This reduced capacity most likely translates into a need for greater assistance, which has both economic and human costs.<sup>203</sup> Thus, there are real, negative consequences, from an objective standpoint, in permitting persons to refuse psychiatric treatment.

Persons who refuse antipsychotic treatment will have untreated symptoms of a disease that could lead them to pose an increased risk of harm to self or others. Active risk of harm to self or others will, in nearly all cases, override an advance directive decision that refuses treatment.<sup>204</sup>

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<sup>200</sup> An extant psychiatric diagnosis—and perhaps even a prior psychotic episode—may be a *sine qua non* for executing a psychiatric advance directive. *See, e.g.*, HAW. REV. STAT. §§ 327F-1 to -3 (1993); Backlar, *supra* note 192, at 840. This seems to be a wise requirement. To the extent that advance directives come under attack as violating informed consent, a person who has experienced the conditions about which she is now seeking to articulate future binding choices is certainly more likely to be making an informed choice than is a person who is merely speculating about treatment for an illness that she does not yet have.

<sup>201</sup> It is true, of course, that refusing or ceasing treatment will not inexorably cause death. Karen Ann Quinlan, the subject of *In re Quinlan*, for example, survived (albeit in a coma) until June 11, 1985, more than nine years after she was removed from life support on May 22, 1976. Catherine J. Jones, *Teaching Bioethics in the Law School Classroom: Recent History, Rapid Advances, the Challenges of the Future*, 20 AM. J.L. & MED. 417, 417 nn.3-4 (1994).

<sup>202</sup> *See, e.g.*, Sally R. Szymanski et al., *Course of Treatment Response in First-Episode and Chronic Schizophrenia*, 153 AM. J. PSYCHIATRY 519 (1996).

<sup>203</sup> Economic costs as a significant state interest have a mixed history. *See, e.g.*, Mathews v. Eldridge, 424 U.S. 319 (1976). However, persons are permitted to make health and recreation decisions every day that lead to astronomical economic costs.

<sup>204</sup> For a discussion of when an advance directive may permissibly be overridden, see *infra* Part III.D.3.



Notwithstanding the objectively negative consequences, permitting the right to refuse treatment in the face of such possibilities demonstrates an appropriately high regard for autonomy that is consistent with longstanding legal principles. For physical care advance directives, persons are allowed to refuse treatment even though the inevitable consequence is death. Therefore, persons with mental illness should be permitted to make treatment choices, including refusal of treatment, when the results are less severe.

The decision to refuse treatment is typically scrutinized more carefully than is the choice to assent to treatment recommended by a health care professional.<sup>205</sup> Patients who accede to a doctor's recommendation—who, in essence, give informed consent, are unlikely to be challenged. On the other hand, patients who reject a doctor's prescribed wisdom are much more likely to subject their competence to questioning.<sup>206</sup>

Legally, however, an advance directive refusing treatment is more likely to enjoy constitutional protection than is an advance directive consenting to treatment.<sup>207</sup> There is a clear right to refuse health care treatment for both physical and psychiatric illnesses.<sup>208</sup> The right to receive treatment, however, is far less clear.<sup>209</sup> This is true especially if the treatment is one that is experimental, controversial, or contrary to the treating professional's clinical judgment.<sup>210</sup> Moreover, if an advance directive authorizes hospitalization, then there may be constitutional concerns implicating both the Thirteenth and Fourteenth Amendments.<sup>211</sup>

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<sup>205</sup> See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 27-46 (1991).

<sup>206</sup> See Susan Stefan, *Race, Competence Testing, and Disability Law: A Review of the MacArthur Competence Research*, 2 PSYCHOL. PUB. POL'Y & L. 31, 35 (1996).

<sup>207</sup> See Winick, *supra* note 6, at 70-71. Professor Winick, however, suggests that in cases where a person of questionable competence is seeking to revoke a prior advance directive and where that revocation would result in rejection of treatment or hospitalization recommended by a therapist, that decision should be more strictly scrutinized. See *id.* at 91-94.

<sup>208</sup> See *Riggins v. Nevada*, 504 U.S. 127 (1992); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>209</sup> See *Youngberg v. Romeo*, 457 U.S. 307, 316-20 (1982).

<sup>210</sup> Several advance directive statutes permit doctors to refuse to follow an advance directive that contravenes medical judgment or, occasionally, religious or moral beliefs. See, e.g., MASS. ANN. LAWS ch. 201D, § 14 (Law. Co-op. 1994).

<sup>211</sup> See Dresser, *supra* note 6, at 792-808 (arguing that forced hospitalization through a voluntary commitment contract is akin to slavery).

### 3. *Enforceability*

#### a. *Overview*

Conceptually, mental health advance directives are legally unassailable; however, their enforceability may be more difficult to achieve. Although the *Cruzan* case assumed the existence of a right to refuse treatment,<sup>212</sup> it also upheld the state's right to require proof of a person's desire to refuse treatment by the heavy burden of clear and convincing evidence.<sup>213</sup> Thus, a state may regulate mental health advance directives, even if it may not prohibit them.<sup>214</sup>

What factors would enhance enforceability? First, the person signing an advance directive must be competent at the time of the document's execution. Second, advance directives that refuse treatment have a better claim to constitutional protection than do those consenting to treatment.<sup>215</sup> Advance directives that specifically address the extant medical condition are less likely to raise concerns of lack of informed consent or clinical inappropriateness in violation of medical ethics. Further, statutory schemes that provide immunity for the good faith adherence to an advance directive<sup>216</sup> are more likely, as a practical matter, to procure physicians' cooperation.

Even assuming competence, specificity, immunity, and rejection of rather than request for treatment, mental health advance directives are not beyond attack. Although some state interests regarding physical health care advance directives are not as strong when considered in the context of mental health advance directives,<sup>217</sup> other state interests and powers are stronger. These interests and powers, discussed below, interfere with the unfettered use of mental health advance directives.

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<sup>212</sup> *Cruzan*, 497 U.S. at 279.

<sup>213</sup> *Id.* at 284.

<sup>214</sup> The U.S. Supreme Court has never directly ruled on the issue of mental health advance directives. It has, however, found constitutional protections in the right of incompetents to refuse treatment and, in the prison context, the right to refuse psychiatric medications. *See Riggins v. Nevada*, 504 U.S. 127 (1992); *Cruzan*, 497 U.S. at 261; *Washington v. Harper*, 494 U.S. 210 (1990). It is hard to fathom how the Court could, consistent with these rulings, find against the right to execute mental health advance directives.

<sup>215</sup> *See supra* note 207 and accompanying text.

<sup>216</sup> *See HAW. REV. STAT. § 327F-13* (1993); *OKLA. STAT. ANN. tit. 43A, § 11-112* (West Supp. 2000); *OR. REV. STAT. § 127.555* (1999).

<sup>217</sup> *See supra* notes 189-91 and accompanying text.

*b. The State's Parens Patriae and Police Powers*

There are several state interests that are routinely balanced against an individual's right to refuse life-saving medical treatment. Those interests include preserving an individual's life, preserving the sanctity of life generally, preventing suicide, and maintaining the integrity of medical ethics.<sup>218</sup> Typically, however, those interests will yield to a clearly articulated decision to refuse such treatment.<sup>219</sup>

The refusal of psychiatric medical treatment, on the other hand, has different state interests that must be weighed when determining whether an individual's right to refuse treatment can be honored. The U.S. Supreme Court cases most directly on point have occurred within the criminal justice setting and implicated issues of control and safety within prisons and jails.<sup>220</sup> Outside the penal context, there are other state interests that are balanced against the right to refuse. The state's parens patriae and police powers each provide an independent state interest that might, under certain circumstances, validly override a mental health advance directive.<sup>221</sup>

*i. Parens Patriae*

The state's parens patriae power vests in the state the authority to help those deemed incapable of helping themselves.<sup>222</sup> Persons with mental illness have historically been among the prime objects of this power.<sup>223</sup> Parens patriae is one of the powers by which states can involuntarily commit the mentally ill and, in some cases, treat them against their will.<sup>224</sup> If, however, a person with a psychiatric disorder prepares an advance directive while competent, there is no valid basis for exercising the state's parens patriae power because the person has made the choice while

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<sup>218</sup> *Cruzan*, 497 U.S. at 271.

<sup>219</sup> *See id.* at 273.

<sup>220</sup> *See Riggins v. Nevada*, 504 U.S. 127 (1992); *Washington v. Harper*, 494 U.S. 210 (1990).

<sup>221</sup> *See Grant H. Morris, Defining Dangerousness: Risking a Dangerous Definition*, 10 J. CONTEMP. LEGAL ISSUES 61, 74-85 (1999) (discussing the risks and problems of conflating parens patriae and police powers).

<sup>222</sup> Under English common law, parens patriae was the power of the crown to care for the infirm and incompetent. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 600 (1982).

<sup>223</sup> *See id.* Children are the other typical beneficiaries. *See id.*

<sup>224</sup> *See Addington v. Texas*, 441 U.S. 418, 426-27 (1979); *O'Connor v. Donaldson*, 422 U.S. 563, 583-84 (1975) (Burger, C.J., concurring).

competent.<sup>225</sup> Indeed, the *parens patriae* power has been characterized as a “default rule” applicable only in the absence of a valid advance directive.<sup>226</sup>

Even if competent persons choose, either presently or prospectively, actions that will cause them harm, that choice is theirs and should not be overridden under the guise of *parens patriae*. This easy and clear view of *parens patriae*, as applying only after a determination of an individual’s incompetence,<sup>227</sup> is honored in the breach. The literature is replete with two concepts: first, that the right to refuse treatment is a fundamental right that adheres even in the face of death,<sup>228</sup> and second, that *parens patriae* is a beneficent state power<sup>229</sup> to help persons incapable of helping themselves and thus is applicable only when a person lacks capacity.<sup>230</sup> Nonetheless, *parens patriae* authority is often invoked to prevent harm to persons who, while competent, have chosen a course that will probably—or perhaps inexorably—result in harm.<sup>231</sup> This dichotomy is one example of how mental health care decisions are treated differently. Persons with physical illnesses are allowed to make choices that will end in death but persons with mental illness often are not allowed to make decisions with results less severe.

## ii. Police Power

In certain circumstances police power may also appropriately override a valid advance directive. While persons may have the right to decline life-

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<sup>225</sup> At least one state with specific statutory authority for mental health advance directives creates an exception that allows for divergence from a patient’s wishes. See OR. REV. STAT. § 127.720 (1999).

<sup>226</sup> Winick, *supra* note 6, at 70.

<sup>227</sup> “We are persuaded that *parens patriae* is not broad enough to control medical decisions of a competent person.” *In re K.K.B.*, 609 P.2d 747, 750 (Okla. 1980).

<sup>228</sup> See, e.g., *Zant v. Prevatte*, 286 S.E.2d 715 (Ga. 1982) (holding that a prisoner has a right to starve himself to death). The prisoner was rational with no evidence of abnormal behavior “except to the extent it is not normal to starve oneself.” *Id.* at 716. But see *State ex rel. White v. Narick*, 292 S.E.2d 54 (W. Va. 1982) (holding that a prisoner does not have right to starve himself).

<sup>229</sup> Some say that this is the time to be most wary of state power. See, e.g., David J. Rothman, *Introduction* to WILLARD GAYLIN ET AL., *DOING GOOD: THE LIMITS OF BENEVOLENCE* at ix, x (1978).

<sup>230</sup> See Winick, *supra* note 6, at 64-65.

<sup>231</sup> See, e.g., *In re Gertrude K.*, 675 N.Y.S.2d 790 (N.Y. Sup. Ct. 1998). In addition, risk of harm to self is a ground for civil commitment, which is a classic exercise of *parens patriae* power.

sustaining treatment, or treatment that will result in psychiatric stabilization, they do not have the right to refuse treatment if that refusal will lead them to be a danger to others. The police power is appropriately exercised, therefore, if there is a risk to the community.<sup>232</sup>

While it is hard to quibble with the exercise of police powers to avoid harm to others, the state should not use its police powers to intervene to prevent harm to self.<sup>233</sup> Although recent changes to civil commitment laws have made involuntary commitment easier by permitting commitment for reasons short of risk of harm to self,<sup>234</sup> this more lenient standard should not be grounds to override an advance directive declining treatment. Just as choices regarding traditional medical treatment are subjective and not to be judged by an objective standard,<sup>235</sup> so should decisions regarding mental health treatment, provided they are made when a person is competent. Bad decisions or decisions unsupported by professionals, which

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<sup>232</sup> See *Addington v. Texas*, 441 U.S. 418, 426 (1979).

<sup>233</sup> In *Rivers v. Katz* the court sanctioned this use of the police powers, in a case otherwise very sensitive to the rights of the mentally ill. *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986). "Where the patient presents a danger to himself . . . the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections." *Id.*

<sup>234</sup> See Darold A. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 MARQ. L. REV. 759, 780-83 (1999) (discussing Wisconsin's "Fifth standard," which permits commitment upon a showing of a need for treatment, among other things); see also N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney Supp. 2001). New York's new "assisted outpatient treatment" law, known as Kendra's Law, can force court-ordered treatment upon someone in the community if that person, among other things, has a mental illness, is unlikely to survive safely in the community without supervision (based upon a clinical, not legal judgment), and is unlikely to voluntarily participate in treatment. *Id.* Governor George Pataki signed the law on August 9, 1999, with the right to file petitions taking effect ninety days later. Martin G. Karopkin, *An Overview of Kendra's Law; The New Mental Health Law*, N.Y. L.J., Oct. 7, 1999, at 1. This law appears to eviscerate the notion of the right to refuse, by allowing forced treatment on grounds short of that necessary for involuntary commitment. See N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney Supp. 2001). Kendra's Law acknowledges the health care proxy law and requires that any instruction contained in that proxy be considered in fashioning a treatment plan, but makes it clear that a person who has appointed a proxy may still be subject to outpatient treatment. *Id.* § 9.60(c)(8)-(d).

<sup>235</sup> See *In re Westchester County Med. Ctr. ex rel O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988).

are likely to be the decisions that are labeled bad,<sup>236</sup> have legal authority as long as the person making them is competent. It should not matter whether the decisions involve physical or psychiatric care.

More troubling is the right to refuse treatment if that refusal may lead to suicide. Closer inquiry, however, shows that a potential suicide may not be sufficient to invoke police powers. Although there is no fundamental right to assisted suicide,<sup>237</sup> a person refusing medication may not be intent upon dying, but rather may “ferently wish to live, but to do so free of unwanted medical technology, surgery, or drugs.”<sup>238</sup> If suicide is not the intent but rather the byproduct of the cessation of medication, it is of a kind with those deaths resulting from the cessation of breathing tubes or other life-saving treatment. Thus, it would be consistent with the U.S. Supreme Court’s “distinction between letting a patient die and making that patient die.”<sup>239</sup>

Even assuming, however, that suicide is intended, and further that the state may legitimately act to prevent this, it is possible that confinement is a better choice than forced administration of medication.<sup>240</sup> If the right to refuse treatment is in fact a fundamental right, the state can abridge it in very limited circumstances. The U.S. Supreme Court has stated that involuntary psychiatric treatment is more invasive of liberty interests than is routine confinement.<sup>241</sup> Accordingly, confinement without invasive medical treatment would be a more constitutionally acceptable exercise of state police power in preventing suicide.<sup>242</sup>

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<sup>236</sup> A person’s mere profession of disagreement with a proposed treatment plan is likely the action that leads a doctor to seek court authority to provide non-consensual treatment based upon a person’s asserted incompetence. *See* Stefan, *supra* note 206, at 35.

<sup>237</sup> *See* Washington v. Glucksberg, 521 U.S. 702, 719-28 (1997).

<sup>238</sup> *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

<sup>239</sup> *Vacco v. Quill*, 521 U.S. 793, 807 (1997).

<sup>240</sup> One could argue that in the case of involuntary hospitalization, confinement and treatment are the same thing. The possibility of suicide is an excellent example of the utility of an advance directive. If persons know that, as a result of mental illness, they are likely to become suicidal, they could dictate in an advance directive the preferred course of action—confinement or drug treatment.

<sup>241</sup> *See* Vitek v. Jones, 445 U.S. 480, 492-94 (1980).

<sup>242</sup> Professor Richard Bonnie also argues in favor of confinement or seclusion over forced medication, albeit in the slightly different circumstance of dealing with “emergencies” involving involuntarily committed yet competent patients. Bonnie, *supra* note 26, at 24. He reasons that confinement and seclusion are easier to monitor and less invasive. *Id.*

Confinement without treatment is subject to legitimate criticism.<sup>243</sup> First, it harkens back to days when institutional abuses of warehousing patients gave rise to extensive class action suits.<sup>244</sup> Further, mental health personnel would argue that their mission is to treat rather than to confine and that the latter without the former violates the Hippocratic Oath. Although this is a legitimate medical ethical concern, patient autonomy generally prevails over medical ethics.<sup>245</sup> The solution cannot be to uphold the Hippocratic Oath at the expense of fundamental constitutional rights. The solution may be to create an intermediate placement where the goal is safety, not treatment.<sup>246</sup>

*c. Overriding Advance Directives*

There are anecdotal and documented stories of medical professionals failing to adhere to advance directives.<sup>247</sup> This may be an example of doctors inadvertently acting in a way to invite lawsuits, rather than out of a fear of them. Following an advance directive, particularly in a state where there is immunity for good faith adherence to directives, is not likely to result in litigation—at least not successful litigation. On the other hand, a doctor's failure to follow a clear and validly executed advance directive flies in the face of patient rights and could expose the doctor to liability.<sup>248</sup>

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<sup>243</sup> See Eugene J. Comey, *Patients' Rights: Too Much Courting, Not Enough Caring*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS: VALUES IN CONFLICT 49, 49-50 (A. Edward Doudera & Judith P. Swazey eds., 1982).

<sup>244</sup> See *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972).

<sup>245</sup> See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); see also *In re Guardianship of Browning*, 568 So. 2d 4 (Fla. 1990).

<sup>246</sup> It is undeniable that this solution suggests horrific images. So too, however, does the notion of patients exercising a right to refuse a particular treatment that can lead to death. If we refuse to force treatment that sustains life, how can we force treatment that sustains sanity? Moreover, forced medication that is used primarily, or exclusively, as a restraint is a far cry from "treatment" and is universally condemned. See Litman, *supra* note 25, at 1738-40 (explaining that the forcible use of medication as a restraint is violative of professional standards, is unconstitutional in a prison setting, and unlawful based on a common law battery analysis).

<sup>247</sup> See Backlar, *supra* note 161, at 262.

<sup>248</sup> In *Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E.2d 225 (Ohio 1996), the Ohio Supreme Court stated that:

unwanted life-saving treatment does not go undeterred. Where a patient clearly delimits the medical measures he or she is willing to undergo, and

Assuming that advance directives are sometimes ignored, the question remains whether there are occasions on which they may be properly ignored—for example, when they are superseded by other, weightier values. The question can be broken down even further: are there times when persons may overrule their own advance directive or when medical personnel may refuse to honor it?<sup>249</sup> Thus, central to determining whether an advance directive may be overridden is the competence of the person executing it.<sup>250</sup> The proffered reason for the refusal of medication or, more generally, treatment, could very well influence whether the person is considered competent and thus whether the refusal is deemed valid.

Competence is a common legal requirement. It is a necessary predicate for the valid execution of many legal transactions from wills to contracts to marriage. It is also an aspect of “informed consent” for treatment or the refusal thereof, and it is a requirement to stand trial for a criminal offense. In the past decade, there have been studies assessing the competence and decision-making capacity of persons hospitalized with mental illness.<sup>251</sup> One study reports that persons hospitalized with mental illness have impaired decision-making capacity when compared to those hospitalized for physical illnesses and those not hospitalized.<sup>252</sup> When all four measures gauging competence<sup>253</sup> were analyzed, those diagnosed with schizophrenia

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a health care provider disregards such instructions, the consequences for that breach would include the damages arising from any battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals.

*Id.* at 229. Such language notwithstanding, the court did not find the hospital liable. *Id.*

<sup>249</sup> A competent person may generally change or rescind an advance directive at any time. *See, e.g.*, OKLA. STAT. ANN. tit. 43A, § 11-109 (West Supp. 2000). There has been discussion in some quarters of a wholly irrevocable advance directive structured such that even a competent person could not later revoke it. *See* Winick, *supra* note 6, at 86-87; *supra* notes 169-80 and accompanying text.

<sup>250</sup> *See generally* Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996) (examining competence standards in general).

<sup>251</sup> *See, e.g.*, MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, THE MACARTHUR TREATMENT COMPETENCE STUDY EXECUTIVE SUMMARY (1999), <http://ness.sys.virginia.edu/macarthur/treatment.html>.

<sup>252</sup> *See id.*

<sup>253</sup> Those measures are the abilities to: state a choice, understand relevant information, appreciate the nature of one's own illness, and reason with information. *Id.*



were impaired on at least one of four measures fifty percent of the time, and those who carry a diagnosis of depression scored as impaired twenty-five percent of the time.<sup>254</sup> As the study authors point out, these four factors do not necessarily correspond to any particular jurisdiction's test for competence.<sup>255</sup> So, of the fifty percent of persons with schizophrenia who were found impaired if all four measures were examined, fully one-half of those performed adequately when only one measure was examined.<sup>256</sup> In another study of the use of computer-based advance directives by persons with mental illness, only ten percent failed the screening portion designed to eliminate those who lacked capacity.<sup>257</sup>

There are numerous tests for competence.<sup>258</sup> The minimalist approach finds competence if a patient is able to communicate assent or objec-

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<sup>254</sup> See *id.*

<sup>255</sup> See *id.*

<sup>256</sup> See Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149, 171 (1995).

<sup>257</sup> See Paul Sherman, *Computer-Assisted Creation of Psychiatric Advance Directives*, 34 COMMUNITY MENTAL HEALTH J. 351 (1998).

<sup>258</sup> See, for example, *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986), in which the Court of Appeals of New York cited with approval an eight-part test for assessing competence. Those factors include:

- (1) the person's knowledge that he has a choice to make; (2) the patient's ability to understand the available options, their advantages and disadvantages; (3) the patient's cognitive capacity to consider the relevant factors; (4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; (5) the absence of any interfering emotional state, such as severe manic depression, euphoria or emotional disability; (6) the absence of any interfering pathologic motivational pressure; (7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; (8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does.

*Id.* at 344 n.7. The court in *In re Israel*, 664 N.E.2d 1032 (Ill. App. Ct. 1996), used different factors. That court considered the following:

- (1) The person's knowledge that he has a choice to make; (2) The person's ability to understand the available options, their advantages and disadvantages; (3) Whether the commitment is voluntary or involuntary; (4) Whether the person has previously received the type of medication or treatment at issue; (5) If the person has received similar treatment in the

tion.<sup>259</sup> At the other end of the spectrum there is a multi-step process which culminates with a requirement that the decision-making process be logical.<sup>260</sup> Further, it matters to some whether the decision being assessed for competency is a decision to assent to treatment or a decision to object.<sup>261</sup>

Most tests, however, have three main elements. The following components of competence are fairly representative. To be competent, a person must have the ability to: 1) communicate a choice; 2) understand relevant information; and 3) appreciate the situation and its likely consequences.<sup>262</sup> Properly applied then, competence is about the decision-making process, not the result. The challenge for lawyers, judges, family members, and doctors is to refrain from declaring persons incompetent simply because they have reached a different, and perhaps a bad, decision.<sup>263</sup> As courts have noted in cases of traditional medical decision-making, the choice is

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past, whether he can describe what happened as a result and how the effects were beneficial or harmful; and (6) The absence of any interfering pathologic perceptions or beliefs or interfering emotional states which might prevent an understanding of legitimate risks and benefits.

*Id.* at 1040.

<sup>259</sup> Berg et al., *supra* note 250, at 352-53. "Inability to communicate a decision means that the patient is unable effectively to make known his or her wishes regarding treatment. Many courts use this element for a threshold determination of competence." *Id.*

<sup>260</sup> *See id.* at 357-58.

<sup>261</sup> *See* Winick, *supra* note 6, at 70-72 (positing that advance directives providing for certain treatments may be afforded less constitutional protection than advance directives rejecting treatments).

<sup>262</sup> Berg et al., *supra* note 250, at 351. These components are fairly common; an additional one, the ability to manipulate information rationally, is less so. *Id.* at 357. Although competence is a legal determination and capacity a medical one, the two standards are remarkably similar. Capacity is assessed by evaluating:

- 1) the patient's understanding of the reason for the proposed treatment and how to apply it to the patient's circumstances; 2) the patient's ability to understand the risks, benefits, and alternatives to the proposed treatment; 3) the patient's ability to rationally weigh these considerations; 4) the patient's ability to communicate his/her decisions and the basis for the decisions; and 5) whether the decision is voluntary.

Sales, *supra* note 163, at 170.

<sup>263</sup> *See In re Virgil D.*, 524 N.W.2d 894, 898-900 (Wis. 1994) (holding that the focus in such cases should be on whether the patient understands the implications of his decision, not on whether the decision is good or bad).

subjective and should not be assessed in an objective fashion using societal standards.<sup>264</sup>

If individuals are aware of their illness, know that there are drugs that will help combat the illness, but decide that they do not want the drugs, must they explain why? Under some formulas for testing competence, the answer is yes.<sup>265</sup> But should it be so? As one treatise on torts explains regarding the law of informed consent, "individual freedom . . . is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones."<sup>266</sup> Richard Cole, one of the lawyers for the plaintiffs in *Rogers v. Okin*,<sup>267</sup> suggests that psychiatrists seek what other doctors do not have—the right to make decisions for patients.<sup>268</sup> If he is correct, and there is evidence that he is,<sup>269</sup> there is no justification for differential treatment.

One rational explanation for refusing treatment is the harmful, often irreversible, and occasionally fatal side effects of antipsychotic medication. Commentators and courts alike have detailed the often horrific effects of drug therapy and other forms of mental health treatment.<sup>270</sup> Further, side

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<sup>264</sup> *In re Peter*, 529 A.2d 419, 423 (N.J. 1987) ("Medical choices . . . are not to be decided by societal standards of reasonableness or normalcy. Rather, it is the patient's preferences—formed by his or her unique personal experiences—that should control.").

<sup>265</sup> See Berg et al., *supra* note 250, at 357-58; cf. Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 119 (1999) (proposing a "patently false delusional belief" standard for competency as a compromise between an "impossible belief" standard and a "believe what your doctor believes" standard).

<sup>266</sup> HARPER & JAMES, *supra* note 3, at 61. We are inconsistent as a society about the types of foolish choices we will permit. For instance, states have begun passing mandatory seatbelt laws but have also increased speed limits, which will result in increased fatalities.

<sup>267</sup> See *supra* note 29 for the procedural history of *Rogers v. Okin*.

<sup>268</sup> Richard Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS: VALUES IN CONFLICT 56, 68 (A. Edward Doudera & Judith P. Swazey eds., 1982).

<sup>269</sup> The American Psychiatric Association in amicus briefs for the *Rennie* and *Rogers* cases sought to have the course of treatment for all civilly committed patients determined by the psychiatrist, with or without the patient's consent. See *Comey*, *supra* note 243, at 49-50.

<sup>270</sup> Some of the most common side effects of psychotropic drugs are tardive dyskinesia, akathisia, acute dystonia, and neuroleptic malignant syndrome. See *Riggins v. Nevada*, 504 U.S. 127, 134 (1992); *Washington v. Harper*, 494 U.S. 210, 229-30 (1990); Brooks, *supra* note 27, at 947-51.

effects have not disappeared with the recent spate of psychiatric medication. Death by virtue of a lower white blood cell count is a possibility with Clozapine, a relatively new antipsychotic drug.<sup>271</sup> Accordingly, patients who receive it must also get weekly blood tests.<sup>272</sup> Can a patient who rejects Clozapine because of a fear of needles be deemed competent, notwithstanding the drug's potential<sup>273</sup> to remediate psychosis? Or would such a fear be denominated irrational and thus forced treatment sought? What if a patient demurred based upon her aversion to death?<sup>274</sup> Is that reason sound, or should it be rejected because the risk is only slight?

What about lesser reasons? What if, for instance, the drug is merely unpleasant?<sup>275</sup> Among the reasons cited in litigation for refusal to take medication are dislike of the slow, drugged feeling, fear of permanent side effects, and basic lethargy.<sup>276</sup> Perhaps there are two drugs that produce the same positive effects, though one makes the person feel lethargic and the other does not.<sup>277</sup> Patients with bipolar disorder may refuse medication because they are very productive and creative in the hypomanic states that precede full-blown and often psychotic mania.<sup>278</sup> Or what if they just like the euphoria, even without the corresponding productivity? Others may decide that they dislike drugs' effects on their sexual functioning.

Who is to decide which of these reasons is reasonable? Should that determination ever be required? For instance, in *Toraty v. Mental Hygiene Legal Services (In re Joseph "O")*,<sup>279</sup> the court upheld Joseph O.'s compe-

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<sup>271</sup> PHYSICIANS' DESK REFERENCE 2008-09 (54th ed. 2000).

<sup>272</sup> *Id.* at 2008.

<sup>273</sup> The qualifier is necessary here because a full twenty percent of mentally ill persons have virtually no response to antipsychotic medication. Brooks, *supra* note 27, at 946.

<sup>274</sup> Even the ubiquitously mainstreamed Prozac has been alleged to cause violence. Although the manufacturer, Eli Lilly, has successfully defeated lawsuits, a suit was recently filed based upon the manufacturer's purchase of a patent that warns against possible side effects of violence and suicide. *See Mitchell Zuckoff, Prozac Data Was Kept From Trial, Suit Says*, BOSTON GLOBE, June 8, 2000, at A1.

<sup>275</sup> *See, e.g., In re Miller*, 705 N.E.2d 144 (Ill. App. Ct. 1998). Mr. Miller opposed taking medication because, "I don't like needles." *Id.* at 147.

<sup>276</sup> Cole, *supra* note 268, at 61.

<sup>277</sup> Such examples are not fanciful. Different drugs used to treat the same symptoms may well affect the consumer in radically different ways. *See, e.g., Toraty v. Mental Hygiene Legal Servs. (In re Joseph "O")*, 666 N.Y.S.2d 322, 323 (N.Y. App. Div. 1997).

<sup>278</sup> *See generally* KAY REDFIELD JAMISON, AN UNQUIET MIND (1995).

<sup>279</sup> *Joseph "O"*, 666 N.Y.S.2d at 322.

tence to refuse drugs when the trial testimony indicated that he knew his medical history, including a diagnosis of paranoid schizophrenia, and that he was aware that his condition had been stabilized on medication for twenty years.<sup>280</sup> His current refusal of medication was based upon his belief that his schizophrenia had been ameliorated by prolonged exposure to the sun.<sup>281</sup> The court found that Joseph O. had capacity, citing his clearly expressed desire to remain institutionalized if that was the cost of refusing medication.<sup>282</sup>

There is much debate over whether persons with mental illness must comprehend that they have a mental illness in order to be competent to consent to or refuse treatment. The waters are even murkier: does "comprehend" mean awareness that a diagnosis of mental illness has been rendered or agreement with that diagnosis?<sup>283</sup> In *Virgil D. v. Rock County (In re Virgil D.)*,<sup>284</sup> the Supreme Court of Wisconsin declared that a person need not accept that she has a mental illness, only that she understands the risks, benefits, and alternatives to the proposed psychotropic medications.<sup>285</sup> It thus reversed a lower court order permitting forced medication based upon a psychiatrist's testimony that Virgil was incompetent to consent or refuse "because he had no insight into his own mental illness."<sup>286</sup>

#### IV. STATE RESPONSES

##### A. Statutory Law

There are three ways a state may enact legislation that provides for mental health advance directives.<sup>287</sup> First, a state may amend its generic

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<sup>280</sup> *Id.* at 324. The refusal to take medication after twenty years of successful treatment arose after Joseph O.'s doctor changed Joseph O.'s medication, from Stelazine to Risperdal, at the request of his brother. *Id.* at 323. The case does not indicate that the doctor obtained informed consent from Joseph O. before making the change, nor does it reveal any side effects of the new drug that may have caused Joseph O. to begin to resist the administration of any medication. *See id.* at 323-24. This poignant example underscores both the helpfulness and uncertainty of psychotropic medication.

<sup>281</sup> *Id.* at 324.

<sup>282</sup> *Id.* The court did consider it a close call. *Id.*

<sup>283</sup> *See* Robert D. Miller, *Advance Directives for Psychiatric Treatment: A View from the Trenches*, 4 PSYCHOL. PUB. POL'Y & L. 728, 739 (1998); Cuca, *supra* note 172, at 1169.

<sup>284</sup> *Virgil D. v. Rock County (In re Virgil D.)*, 524 N.W.2d 894 (Wisc. 1994).

<sup>285</sup> *Id.* at 898. This was a statutory standard, enacted in response to a judicially acknowledged right to refuse. *Id.*

<sup>286</sup> *Id.* at 896.

<sup>287</sup> *See generally* Fleischer, *supra* note 150 (describing the different types of advance directive statutes).

advance directive, durable power of attorney for health care, or health care proxy statutes to include mental health care decisions.<sup>288</sup> Several states have enacted discrete statutes that address mental health care decisions exclusively.<sup>289</sup> Some states have done both,<sup>290</sup> although such a course may invite confusion.<sup>291</sup> Finally, in states where legislatures have not taken explicit action regarding mental health care decisions, the standard advance directive ought to suffice, provided that it does not specifically exclude mental health decisions.<sup>292</sup>

The statutes have many similarities; many of the combination statutes are patterned after the Uniform Health Care Decisions Act.<sup>293</sup> The Uniform Act's definition of health care provides that health care "means any care,

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<sup>288</sup> See, e.g., MASS. ANN. LAWS ch. 201D, § 6 (Law. Co-op. 1994).

<sup>289</sup> See, e.g., HAW. REV. STAT. §§ 327F-1 to -16 (1993); 755 ILL. COMP. STAT. ANN. 43/1 - 43/115 (West Supp. 2000); OR. REV. STAT. §§ 127.700 - .737 (1999).

<sup>290</sup> See HAW. REV. STAT. §§ 327D-1 to -27, 327F-1 to -16 (1993); 755 ILL. COMP. STAT. ANN. 43/1 - 43/115 (West Supp. 2000), 45/4-1 - 45/4-12 (West 1993 & Supp. 2000).

<sup>291</sup> See Rebecca J. O'Neill, *Surrogate Health Care Decisions for Adults in Illinois—Answers to the Legal Questions That Health Care Providers Face on a Daily Basis*, 29 LOY. U. CHI. L.J. 411, 440-42 (1998) (discussing the potential conflicts between the Illinois Mental Health Treatment Preferences Declaration Act and Powers of Attorney for Health Care Law).

<sup>292</sup> Fleischer, *supra* note 150, at 793. Query, however, whether a statute similar to that which Alabama has enacted, which addresses terminal conditions as well as withdrawal of hydration and nutrition—thus fairly clearly referencing physical health care only—would be read to exclude mental health care decisions. See ALA. CODE §§ 22-8A-1 to -13 (1997). Alabama, however, like other states, has potentially more than one generic statute on point. See *id.* § 26-1-2. Many states have both durable power of attorney statutes and health care proxy statutes, each of which could apply. Further, some states have specialized mental health advance directive statutes, as well as guardian statutes. In short, the problem may be too much statutory authority. For a discussion of competing statutes and conflicting authority, see O'Neill, *supra* note 291, at 440-42. Not all commentators agree that general advance directive statutes will work properly for psychiatric conditions. See Stavis, *supra* note 138, at 57.

<sup>293</sup> UNIF. HEALTH-CARE DECISIONS ACT, 9 (I.B) U.L.A. 143 (1999). Six states have adopted this act since 1995: California, Delaware, Hawaii, Maine, Mississippi, and New Mexico. See CAL. PROB. CODE §§ 4600-4805 (West Supp. 2001); DEL. CODE ANN. tit. 16, §§ 2501-2518 (Supp. 2000); HAW. REV. STAT. §§ 327E1 to -16 (Supp. 1999); ME. REV. STAT. ANN. tit. 18-A, §§ 5-801 to -817 (West 1998 & Supp. 2000); MISS. CODE ANN. §§ 41-41-201 to -229 (1999 & Supp. 2000); N.M. STAT. ANN. §§ 24-7A-1 to -18 (Michie Supp. 1996).

treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or *mental* condition."<sup>294</sup> The comments indicate that health care is defined as broadly as possible and should be construed that way.<sup>295</sup> Capacity is defined as "an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."<sup>296</sup> The Uniform Act permits the appointment of a proxy or agent to make health-care decisions that approve or disapprove programs of medication, thus codifying the right to refuse.<sup>297</sup> In its section on revocation, the Uniform Act requires a principal to have capacity in order to execute a valid revocation.<sup>298</sup> In the state statutes, revocations are generally reserved to the competent or capable principal.<sup>299</sup>

There are some troubling statutory provisions. Many states set forth circumstances under which the directive need not be followed.<sup>300</sup> Some of these exceptions have the effect of all but eviscerating the law. For instance, several states allow the directive to be ignored in emergencies, defined to include risk of harm to self.<sup>301</sup> One of the purposes of advance directives, however, is to give voice to patient autonomy in the face of anticipated emergencies. Rendering an advance directive ineffective when such an emergency occurs undercuts the reason for advance directives in the first place.

### B. Case Law

The statutes dealing with mental health advance directives are relatively new and the case law interpreting them is sparse.<sup>302</sup> Some courts,

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<sup>294</sup> UNIF. HEALTH-CARE DECISIONS ACT § 1(5), 9 (I.B) U.L.A. 148 (emphasis added).

<sup>295</sup> *Id.* § 1 cmt, 9 (I.B) U.L.A. 149.

<sup>296</sup> *Id.* § 1(3), 9 (I.B) U.L.A. 148.

<sup>297</sup> *Id.* § 1(6)(ii), 9 (I.B) U.L.A. 148.

<sup>298</sup> *Id.* § 3(b), 9 (I.B) U.L.A. 155. The Uniform Act does specify, however, that a person is presumed to have capacity. *Id.* § 11(b), 9 (I.B) U.L.A. 178.

<sup>299</sup> *See, e.g.*, HAW. REV. STAT. § 327F-10 (1996).

<sup>300</sup> *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, § 5-807(e) (West 1998).

<sup>301</sup> *See, e.g.*, DEL. CODE ANN. tit. 16, § 2508 (Supp. 2000).

<sup>302</sup> There are reasons other than relatively recent statutes that explain the undeveloped state of the case law. Marginalized and stigmatized clients, often poor, or, if of means, estranged from family members, and without any guarantee of counsel, may not have the wherewithal to litigate these issues on the appellate level.

however, have had a chance to rule on the issue. *In re Rosa M.*<sup>303</sup> is the key case in this area.<sup>304</sup> Although not addressing a mental health advance directive executed pursuant to a statute, a New York state court gave binding effect to a patient's written document refusing electroconvulsive therapy.<sup>305</sup>

Rosa M. was committed to a state psychiatric center on February 6, 1990.<sup>306</sup> She was subjected to three rounds of electroconvulsive therapy, presumably with her consent as required by state law.<sup>307</sup> On March 22, 1991, Ms. M. consented again to electroconvulsive therapy; she was, at that time, indisputably competent.<sup>308</sup> She withdrew that consent nineteen days later and there was no indication that she was not equally competent at that point.<sup>309</sup> The clinic director sought a court order authorizing further electroconvulsive therapy over Ms. M.'s written objection.<sup>310</sup> In denying the petition, the court recognized the fundamental right of individuals to have the "final say" and declared that mentally ill persons were entitled to the same status.<sup>311</sup> As no one had demonstrated that Ms. M. lacked capacity, she was entitled to have her say and to have that say bind the medical personnel.<sup>312</sup>

A 1997 Illinois appellate case, *In re Hatsuye T.*,<sup>313</sup> involved an eighty-two-year-old woman who was diagnosed with severe psychotic depression.<sup>314</sup> Mrs. T. executed a durable power of attorney for health care, naming a health care proxy.<sup>315</sup> She later was approached by her doctor, who

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<sup>303</sup> *In re Rosa M.*, 597 N.Y.S.2d 544 (N.Y. Sup. Ct. 1991).

<sup>304</sup> See PARRY, *supra* note 144, at 105.

<sup>305</sup> See *Rosa M.*, 597 N.Y.S.2d at 544-45.

<sup>306</sup> *Id.* at 544.

<sup>307</sup> *Id.*

<sup>308</sup> *Id.*

<sup>309</sup> See *id.* at 544-45.

<sup>310</sup> *Id.* at 544.

<sup>311</sup> *Id.* at 545.

<sup>312</sup> *Id.*

<sup>313</sup> *In re Hatsuye T.*, 689 N.E.2d 248 (Ill. App. Ct. 1997).

<sup>314</sup> *Id.* at 249.

<sup>315</sup> *Id.* at 250. The statutory authority pursuant to which Mrs. T. appointed a proxy was the Powers of Attorney for Health Care Law, 755 ILL. COMP. STAT. ANN. 45/4-1 - 45/4-12 (West 1993 & Supp. 2000), not the state's Mental Health Treatment Preferences Declaration Act, 755 ILL. COMP. STAT. ANN. 43/1 - 43/115 (West Supp. 2000). There is nothing in the opinion to suggest that the proxy was not capable of rendering decisions involving mental health care. See *Hatsuye T.*, 689 N.E.2d at 249-54.



told her that the only option other than electroconvulsive therapy was placement in a nursing home, a statement that was clearly not true.<sup>316</sup> In response, Mrs. T. provided consent to electroconvulsive therapy, which she had previously declined to do, because she feared she would die in a nursing home, as her husband had.<sup>317</sup> Mrs. T. then amended the power of attorney to include instructions that prevented the proxy from consenting to electroconvulsive therapy.<sup>318</sup> Following this, Mrs. T. was discharged and returned to her home.<sup>319</sup> Mrs. T.'s psychotic depression worsened five months later and a petition to forcibly medicate was filed after Mrs. T. was involuntarily committed.<sup>320</sup> The court appointed a guardian and authorized that guardian to consent to as many as ten electroconvulsive therapy treatments over Mrs. T.'s objection, which had been explicitly expressed in the durable power of attorney for health care.<sup>321</sup>

On appeal, the court synthesized the power of attorney statute with the guardianship statute.<sup>322</sup> The court found that provisions of both laws gave an agent appointed pursuant to the power of attorney law supremacy over a guardian in matters covered by the durable power of attorney.<sup>323</sup> Indeed, the court found that the trial court lacked subject matter jurisdiction to appoint a guardian to consent to electroconvulsive therapy in view of the validly executed durable power of attorney for health care.<sup>324</sup> The court thus found the guardianship order to be void.<sup>325</sup>

The doctor's statement to Mrs. T. concerning her options warrants discussion. His statement illustrates the risk of coercion involved in these cases.<sup>326</sup> It is a risk at all levels and from all sides. Coercion is a concern

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<sup>316</sup> *Hatsuye T.*, 689 N.E.2d at 250.

<sup>317</sup> *Id.*

<sup>318</sup> *Id.*

<sup>319</sup> *Id.*

<sup>320</sup> *Id.*

<sup>321</sup> *Id.*

<sup>322</sup> *See id.* at 251.

<sup>323</sup> *Id.*

<sup>324</sup> *See id.* at 251-52.

<sup>325</sup> *Id.* at 252.

<sup>326</sup> *See, e.g.,* MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, THE MACARTHUR COERCION STUDY EXECUTIVE SUMMARY (1999), <http://ness.sys.virginia.edu/macarthur/coercion.html> [hereinafter MACARTHUR COERCION STUDY]. The study found that coercion is not limited to the legal status of involuntary commitment; it can also occur in connection with "voluntary" placements. *Id.* The feeling of coercion, then, is dependent not so much on the type of placement but on whether negative pressures—such as threats—are used, as

throughout the field of advance directives, and not limited to fear of doctor or hospital staff coercion. Some mental health advocates fear that family members may coerce persons with mental illness into signing advance directives, consenting to treatment they do not want. On the other hand, mental health professionals fear that advocates will persuade the mentally ill to reject both needed and wanted prospective treatment.<sup>327</sup>

The courts in *Rosa M.* and *Hatsuye T.* honored a competent patient's future choice to refuse psychiatric treatment.<sup>328</sup> Although there is nothing in either case that indicated a risk of violence,<sup>329</sup> which is a commonly cited ground to seek a judicial countermand to an advance directive, the medical personnel in each case sought electroconvulsive therapy and testified that it was appropriate, notwithstanding the existence of an advance directive.<sup>330</sup> Indeed, in the *Hatsuye T.* case, it was the hospital's discomfort with the power of attorney and its subsequent petition to the court for a guardian that created the circumstances leading to a "no electroconvulsive therapy" edict.<sup>331</sup> Prior to the petition filed by the hospital, Mrs. T. had not forbidden her proxy from consenting to electroconvulsive therapy.<sup>332</sup> Had the hospital recognized the appropriate authority of the proxy, it could have sought and perhaps received consent for the therapy from the proxy.<sup>333</sup>

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opposed to positive pressures—such as persuasion—and whether the process used is fair and the persons involved are genuinely concerned and respectful. *Id.*

<sup>327</sup> See Letter from Mark Heyrman, Mandel Legal Aid Clinic, University of Chicago, to Justine A. Dunlap, visiting Director, Domestic Violence Clinic, American University Washington College of Law (Aug. 1999) (on file with author). Many advance directive statutes explicitly forbid coercion in the execution of advance directives. See, e.g., HAW. REV. STAT. § 327F-12 (1996).

<sup>328</sup> *Hatsuye T.*, 689 N.E.2d at 252; *In re Rosa M.*, 597 N.Y.S.2d 544, 545 (N.Y. Sup. Ct. 1991).

<sup>329</sup> See *Hatsuye T.*, 689 N.E.2d at 249-54; *Rosa M.*, 597 N.Y.S.2d at 544-45.

<sup>330</sup> *Hatsuye T.*, 689 N.E.2d at 250; *Rosa M.*, 597 N.Y.S.2d at 544.

<sup>331</sup> See *Hatsuye T.*, 689 N.E.2d at 250.

<sup>332</sup> *Id.*

<sup>333</sup> It is possible that the proxy was not even in effect, as there was no clear assertion that Mrs. T. was not competent to give or withhold consent. See *id.* at 249-54. Indeed, the evidence is to the contrary: the doctor sought her consent for electroconvulsive therapy and only after it was refused did he go to court to seek a guardian to grant him what his patient would not. *Id.* at 250. The doctor's action is emblematic of studies showing that doctors often rush to a judgment of incompetence when a patient disagrees with them. Presumably, Mrs. T.'s doctor would have happily pronounced her competent if she had signed the electroconvulsive therapy consent form as he had wished.

In another Illinois case, *In re Janet S.*,<sup>334</sup> an Illinois appellate court reversed an order for involuntary administration of medication because the state had failed to allege in its petition, as required by statute,<sup>335</sup> that it had made a good faith effort to ascertain whether the individual in question had executed an advance directive pursuant to the Mental Health Treatment Preference Declaration Act.<sup>336</sup> Illinois is a state with multiple laws in this area and the legislature has made an attempt to coordinate the laws by requiring that the petitioner in an action for forced administration of drugs make an effort to see if an advance directive, which would clearly affect and perhaps preempt a petition, has been completed.<sup>337</sup> The *Janet S.* court declared that it would strictly enforce procedural safeguards as a necessary protection for an individual's liberty interest which is put at risk by the possibility of a regime of forced medication.<sup>338</sup>

Of these three cases, only the third, *In re Janet S.*, recites facts suggesting that the person in question was of potential harm to others.<sup>339</sup> The involuntary treatment order for Janet S. was sought while she was held on charges of aggravated battery and disorderly conduct after having been determined not competent to stand trial.<sup>340</sup> It is curious that in the two cases in which an advance directive was given effect, *In re Rosa M.* and *In re Hatsuye T.*, the request was for electroconvulsive therapy, not psychotropic drugs, for persons whose diagnosis was depression, not schizophrenia.<sup>341</sup> This may be the case because the courts, at least appellate courts,<sup>342</sup> may be

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<sup>334</sup> *In re Janet S.*, 712 N.E.2d 422 (Ill. App. Ct. 1999).

<sup>335</sup> 405 ILL. COMP. STAT. ANN. 5/2-107(a)(1) (West Supp. 2000).

<sup>336</sup> *Janet S.*, 712 N.E.2d at 423-24. Some Illinois appellate courts hold that a failure in the petition to allege such good faith efforts is harmless error. *In re Len P.*, 706 N.E.2d 104, 107 (Ill. App. Ct. 1999); *In re Miller*, 705 N.E.2d 144, 144 (Ill. App. Ct. 1998). The Illinois Mental Health Treatment Preference Declaration Act is found at 755 ILL. COMP. STAT. ANN. 43/1 - 43/115 (West Supp. 2000).

<sup>337</sup> 405 ILL. COMP. STAT. ANN. 5/2-107(a)(1) (West Supp. 2000).

<sup>338</sup> *Janet S.*, 712 N.E.2d at 424.

<sup>339</sup> *Id.* at 423.

<sup>340</sup> *Id.*

<sup>341</sup> The *Hatsuye T.* court specified that Mrs. T.'s disease was "severe psychotic depression with delusional features." *In re Hatsuye T.*, 689 N.E.2d 248, 249 (Ill. App. Ct. 1997). The court in *Rosa M.* did not disclose the nature of her mental illness but it is likely to have been depression if the recommended treatment was electroconvulsive therapy. See *In re Rosa M.*, 597 N.Y.S.2d 544, 544-45 (N.Y. Sup. Ct. 1991).

<sup>342</sup> Both *Janet S.* and *Hatsuye T.* involved appellate reversals of lower court decisions. *Janet S.*, 712 N.E.2d at 423; *Hatsuye T.*, 689 N.E.2d at 254. This leaves

more comfortable giving voice to persons with depression as opposed to those with schizophrenia.<sup>343</sup> It also suggests, however, that treating facilities and personnel are not yet comfortable with autonomy that, when exercised, leaves the individual untreated.

## V. WHY THE HESITANCE?

### A. Introduction

It is hard to argue seriously against autonomy.<sup>344</sup> The list of autonomy proponents<sup>345</sup> is daunting and even the U.S. Supreme Court has joined the call in favor of autonomy in two cases regarding mental health.<sup>346</sup> With this strong philosophical, legal, and even psychological<sup>347</sup> backdrop, what explains the hesitance to embrace mental health advance directives?

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one to wonder how many cases are also decided incorrectly but are not appealed, thus leaving unvindicated the autonomy rights of persons with mental illness.

<sup>343</sup> Public perceptions of these diseases are often not supported by data. For instance, a person diagnosed with depression is more likely to be violent than a person diagnosed with schizophrenia. MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, MACARTHUR VIOLENCE RISK ASSESSMENT STUDY RESPONSE TO THE NATIONAL REVIEW (1998), [http://ness.sys.virginia.edu/macarthur/violence\\_RespnR.html](http://ness.sys.virginia.edu/macarthur/violence_RespnR.html) [hereinafter MACARTHUR RESPONSE].

<sup>344</sup> Some suggest, however, that “many” psychiatric advance directive proponents are not really in favor of autonomy but are, rather, pushing separate ideological agendas. Miller, *supra* note 283, at 743. It is further suggested that these “extreme libertarians” are overrepresented in law review articles. *Id.* at 744.

<sup>345</sup> The high regard for autonomy is longstanding and well-credentialed. Its proponents include John Locke, Thomas Jefferson, Patrick Henry, John Stuart Mill, and Immanuel Kant. See Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1707-15 (1992) (discussing the views of Locke, Jefferson, Henry, Mill, and Kant). “Each is the proper guardian of his own health, whether bodily *or* mental and spiritual.” JOHN STUART MILL, ON LIBERTY 12 (Elizabeth Rapaport ed., Hackett Publ’g Co. 1978) (1859). Mill also stated that “the only purpose for which power can be rightfully exercised over . . . [another], against his will, is to prevent harm to others.” *Id.* at 9. See also WILLIAM O. DOUGLAS, THE RIGHT OF THE PEOPLE 87-90 (Greenwood Press 1980) (1958); Samuel D. Warren & Louis D. Brandeis, *The Right To Privacy*, 4 HARV. L. REV. 193 (1890).

<sup>346</sup> See *Riggins v. Nevada*, 504 U.S. 127 (1992); *Washington v. Harper*, 494 U.S. 210 (1990); *supra* Part II.B.3.

<sup>347</sup> See Winick, *supra* note 345, at 1755-68.

One reason why mental health advance directives have not been endorsed as fully as end-of-life advance directives is no doubt the different nature of the two conditions. Competent persons completing a standard advance directive do so under legal and common sense presumptions of rational thinking.<sup>348</sup> Competent persons afflicted by mental illness, by contrast, operate under a cloud of suspicion regarding their capacity to reason.<sup>349</sup> Accordingly, there may be more hesitation to honor a mental health advance directive because the individual's disease affects the brain. Although it cannot be denied that the issue of competence is genuine and must be addressed,<sup>350</sup> it is quite likely that the concern is overblown.<sup>351</sup>

Advocates for persons with mental illness endorse advance directives, albeit with reservations. The fear of coercion, by family members or mental health professionals, is of concern. This fear is strong enough such that penalties including criminal sanctions against anyone who has coerced someone into or out of signing an advance directive have worked their way into several statutes.<sup>352</sup>

### B. Fear

The hesitation to embrace mental health advance directives also stems from society's general discomfort with mental illness and fear of persons

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<sup>348</sup> Michael Perlin discusses the prejudices wrought in this area by the "use of alleged 'ordinary common sense.'" Michael L. Perlin, *"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 4 (1999). Giving life to these words is another commentator's view that "common sense" indicates that a patient's right to autonomy be given a wide berth when it is consistent with good practice and good economics. Stavis, *supra* note 138, at 49. Query whether that is "autonomy" at all.

<sup>349</sup> See *supra* notes 249-57 and accompanying text.

<sup>350</sup> Because a common symptom of mental illness is denial, mental health professionals will often say that the consumer lacks "insight"—meaning an awareness of her illness. Miller, *supra* note 283, at 739.

<sup>351</sup> Even sophisticated authors, familiar with mental illness, suggest that there be special safeguards to ensure competence for the mentally ill who execute advance directives. See Backlar, *supra* note 161, at 264-65. The way in which society views the mentally ill—and perhaps in particular those who would be so bold as to decline treatment—may have led some states to specify in their advance directive statutes that the decision to make an advance directive should in no way be construed as a sign of incompetence or incapacity. See, e.g., HAW. REV. STAT. § 327F-4(c) (1993).

<sup>352</sup> See, e.g., HAW. REV. STAT. § 327F-12 (1993).

who are mentally ill. After decades of expanding rights for persons with mental illness, there has been, depending upon one's viewpoint, either a backlash against or a reversal of the trend.<sup>353</sup> Those who assert that the rights movement has gone too far argue that it is absurd to permit those who have illnesses affecting their thought processes<sup>354</sup> to make binding decisions about treatment.<sup>355</sup> However, this concern can be answered by adequately addressing the competence issue to ensure that only the competent execute advance directives. There is no need for a wholesale denial of the autonomy rights of persons with mental illness because a minority are not competent.

It seems more likely that the predominant, if typically unarticulated, concern is grounded in fear, stereotype, and prejudice. This prejudice was articulated by the U.S. Supreme Court in *Addington v. Texas*,<sup>356</sup> in which the Court discussed the stigma that attached to involuntary commitments and their adverse social consequences.<sup>357</sup> The stigmatizing of persons with mental illness is highlighted in the recent Surgeon General's report on mental illness.<sup>358</sup> This stigma leads to discrimination and abuse and "deprives people of their dignity."<sup>359</sup>

Professor Michael Perlin has written extensively of the evil of sanism in the development and the application of mental disability law.<sup>360</sup> He

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<sup>353</sup> See Treffert, *supra* note 234, at 770.

<sup>354</sup> Not all mental illnesses are thought disorders. Some, such as bipolar disorder, are classified as mood disorders. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 317 (4th ed. 1994). Some, such as schizo-affective disorder, are hybrids. *Id.* at 273.

<sup>355</sup> See Miller, *supra* note 283, at 739 (arguing that psychiatric advance directives should not be honored if a consumer does not acknowledge her mental illness).

<sup>356</sup> *Addington v. Texas*, 441 U.S. 418 (1979).

<sup>357</sup> "One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma." *Id.* at 429.

<sup>358</sup> U.S. PUB. HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL—EXECUTIVE SUMMARY (1999), <http://www.surgeongeneral.gov/library/mentalhealth/summary.html>.

<sup>359</sup> U.S. PUB. HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL—CHAPTER 1 (1999), <http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html>.

<sup>360</sup> See, e.g., Perlin, *supra* note 348; Michael L. Perlin, *On "Sanism"*, 46 SMU L. REV. 373 (1992) [hereinafter Perlin, *Sanism*]; Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 369 (1994) [hereinafter Perlin, *Therapeutic Jurisprudence*].

defines sanism as "an irrational prejudice, an 'ism,' of the same quality and character of other prevailing prejudices such as racism, sexism, heterosexism, and ethnic bigotry."<sup>361</sup> It is responsible, he asserts, for much of the malfunctioning in the area of mental disability law.<sup>362</sup> Perlin identifies views that he describes as "a few of the sanist myths that dominate our social discourse."<sup>363</sup> These myths include viewing the mentally ill as dangerous, frightening, different, inhuman, lazy, deserving of segregation and ridicule, and presumptively incompetent, especially regarding health care decisions.<sup>364</sup>

Not only are persons with mental illness deemed incompetent to make health care decisions, they are also considered unworthy to do so. It is as if the right to autonomy and bodily integrity must be earned and the mentally ill have not—indeed, cannot—earn it. They cannot behave responsibly with this right, the argument goes, so it is withheld from them. Sanism is evident here because, although many non-mentally ill persons behave irresponsibly and make bad choices, the right of autonomy is not taken from them.<sup>365</sup>

Fear is certainly a piece of the sanist puzzle. This fear dictates seeing a person with mental illness as "the other," as "them,"—meaning "surely not us."<sup>366</sup> The mentally ill are feared for several reasons. First, they may behave differently, oddly, and outside the norm.<sup>367</sup> Second, their actions may move past the merely odd or bizarre and into the realm of the scary or threatening. Further, one out of five persons will be diagnosed with mental illness,<sup>368</sup> thus the threat is all the more acute in view of its capacity to become reality: any one of "us" could become one of "them." Even if we dodge the odds, we are likely to have a daughter, a cousin, a best friend, or a parent who does not. Given the genetic component of mental illness,

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<sup>361</sup> Perlin, *Sanism*, *supra* note 360, at 374.

<sup>362</sup> *See id.* at 374-76.

<sup>363</sup> *Id.* at 393.

<sup>364</sup> *See id.* at 393-98.

<sup>365</sup> Perlin points out that even when the myths are exposed, attitudes are unlikely to change. *Id.* at 398. As the old adage goes, "Don't confuse me with the facts, I have made up my mind."

<sup>366</sup> *Id.* at 389.

<sup>367</sup> Incredibly, one author in the field has suggested that there is no right to behave in a way that "might be offensive to public sensibilities." Stavis, *supra* note 138, at 47. *But see* O'Connor v. Donaldson, 422 U.S. 563, 573-76 (1975) (ridiculing a parallel notion).

<sup>368</sup> U.S. PUB. HEALTH SERV., U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 359, at 3.

having a parent—or, more stereotypically, a crazy aunt in the attic—with mental illness is even more frightening.<sup>369</sup>

Mental illness is also feared because of the perception of loss of control.<sup>370</sup> This loss is frightening when one sees it in others and begins to fear it, rationally or not, in one's own future. The slow pace at which mental health advance directives have been embraced may well be connected to this fear of loss of control and of others who are out of control. Because persons with mental illness seem out of control, society is reluctant to confer upon them the control and autonomy offered through the instrument of an advance directive.<sup>371</sup>

Notwithstanding decades of expanding rights for the mentally ill, practical day-to-day occurrences in courts, hospitals, and community treatment centers are far removed from legally established rights.<sup>372</sup> Judges and other decision-makers ignore or recast standards that have been legally mandated but which seem to them inconsistent with standards of "alleged 'ordinary commonsense.'"<sup>373</sup> This disconnect also seems to be occurring

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<sup>369</sup> Stories, fictionalized or not, about family members with mental illness are legion. See, e.g., Nicholas Dawidoff, *My Father's Troubles: A Memoir of Love and Madness*, NEW YORKER, June 12, 2000, at 58. This propinquity with mental illness can be beneficial, if society can look behind the stereotypes and see such people as human beings first, rather than as being neither more nor less than their mental illness. As the supervising attorney at the Mental Health Law Clinic at the University of Arkansas at Little Rock School of Law, I saw this in action. First, I had to wrestle with my own stereotypes and fears of persons with mental illness, my own dehumanization or—perhaps worse—infantilization of them. It is remarkable and distressing how easy it is for even the lawyer, the "mouthpiece" of the client, to insert her own views of the client's situation and to fail to give voice to the client. Second, I saw that the students (at least some of them), once past the fear, had a chance at identifying with their clients, because the student already knew and loved someone who was mentally ill. Of course, familiarity may have the opposite effect.

<sup>370</sup> Of course, mental illness is only one of several ways that people lose control. Alcohol and drug use are the other obvious examples, but society does not deny people who use (and perhaps abuse) substances the right to complete advance directives.

<sup>371</sup> Other theories of control and advance directives have been offered. It has been suggested that psychiatry is about social control and denying persons diagnosed with mental illness the right of free choice. Perling, *supra* note 11, at 197.

<sup>372</sup> See Perlin, *supra* note 348, at 19-21.

<sup>373</sup> *Id.* at 4. Perlin concedes that the gap between the law on the books and the law in action is not unique to this field, but he asserts it is exacerbated by sanism



in the area of advance directives. Despite a reasonably clear constitutional right, a recent flurry of activity on the legislative front creating additional rights, and decade-old predictions that the concept was about to take off, mental health advance directives are still a hard sell.

### C. Violence

In *Tarasoff v. Regents of the University of California*,<sup>374</sup> the California Supreme Court found that a psychiatrist had a duty to warn a particular third party about threats of harm issued against her by the psychiatrist's patient.<sup>375</sup> The *Tarasoff* holding has been enlarged and become so powerful that psychiatrists are often taught that it is the law, whether or not a similar rule is in place in a particular jurisdiction.<sup>376</sup> What is it about *Tarasoff* that has given it such resonance? Sanism certainly is one possible explanation; it is commonly assumed that persons with mental illness are more violent than are persons who do not carry such a diagnosis.

Violence—threatened or actual, self-directed or directed toward others—is a likely concern of those hesitant to honor an advance directive that refuses psychiatric treatment. To determine whether this fear of violence is a rational justification for ignoring mental health advance directives, one must determine whether the mentally ill are indeed more violent or whether this is an example of unwarranted stereotype. The link between persons with mental illness and dangerousness is, in at least one

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and pretextuality. *Id.* at 20. Perlin defines pretextuality as “courts’ acceptance (either implicit or explicit) of testimonial dishonesty and their decisions to engage in dishonest decision-making in mental disability law cases.” Perlin, *Therapeutic Jurisprudence*, *supra* note 360, at 373. Other authors have addressed the disconnect between law and reality in this area, specifically civil commitments, and reached a different conclusion. Darold Treffert, for example, suggests that this disparity is a good and necessary thing, a practical recalibration as a result of extreme appellate decisions in the area of mental health law. *See* Treffert, *supra* note 234, at 767-77. Based upon my experience as a legal practitioner doing mental health work, I align myself with Perlin here. The inadequacy of all players, illustrated by the cursory nature of the hearings, the brusque and often disrespectful treatment of the client, and the wholesale deference to doctors, demonstrates the pretextuality that Perlin bemoans. Sadly, my experience is far from unique. *See, e.g.,* Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265 (1994).

<sup>374</sup> *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976) (en banc).

<sup>375</sup> *Id.* at 353.

<sup>376</sup> *See* Perlin, *supra* note 348, at 20.

way, not fanciful. Standards for involuntary civil commitments<sup>377</sup> and release of insanity acquittees<sup>378</sup> make a combination of dangerousness and mental illness a requisite for legal intervention. In cases that garner public attention, there is often violence and a corresponding legal consequence. This, then, inextricably links two frightening elements—violence and mental illness—in the mind of the public.

So, while perhaps explainable, the question remains whether the link is fair. The last decade has yielded research in the area, most significantly the MacArthur Violence Risk Assessment Study.<sup>379</sup> Before the MacArthur Study, there were various estimates of psychiatrists' ability to predict dangerousness. One early study suggested that such expert predictions were "less accurate than the flip of a coin,"<sup>380</sup> although more recent studies have altered that estimate.<sup>381</sup>

Predicting a particular individual's potential for violence is a different task, however, from assessing a general correlation between mental illness and violence. The MacArthur Violence Risk Assessment Study examined the incidence of violence committed by persons who had been hospitalized for mental illness and then released to the community.<sup>382</sup> The study concludes that the prevalence of violence is about the same for the non-mentally ill as it is for persons who were no longer hospitalized and who had no signs of substance abuse.<sup>383</sup> The results thus indicate that the mentally ill pose a higher risk of violence only if they are abusing drugs or alcohol.<sup>384</sup> Substance abuse was reported in forty to fifty percent of the

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<sup>377</sup> O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) (holding that "a [s]tate cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends").

<sup>378</sup> See Foucha v. Louisiana, 504 U.S. 71 (1992).

<sup>379</sup> MACARTHUR RESEARCH NETWORK AND THE LAW, MACARTHUR VIOLENCE RISK STUDY EXECUTIVE SUMMARY (1999), <http://ness.sys.virginia.edu/macarthur/violence.html> [hereinafter MACARTHUR VIOLENCE RISK STUDY].

<sup>380</sup> Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 737 (1974).

<sup>381</sup> See John Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10 (1984); Randy K. Otto, *On the Ability of Mental Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 LAW & PSYCHOL. REV. 43 (1994).

<sup>382</sup> MACARTHUR VIOLENCE RISK STUDY, *supra* note 379.

<sup>383</sup> *Id.*

<sup>384</sup> See *id.*; Kirk Heilbrun & Gretchen Witte, *The MacArthur Risk Assessment Study: Implications for Practice, Research, and Policy*, 82 MARQ. L. REV. 733, 756

former patient group,<sup>385</sup> making the co-occurrence of substance abuse and mental illness, with attendant higher risk of violence, significant.<sup>386</sup> But substance abuse by non-mentally ill persons also results in a greater incidence of violence among that population.<sup>387</sup>

The violence of persons with mental illness who are also abusing drugs and alcohol is not any different in kind, i.e., no more severe or random, from the violence committed by those who have not been hospitalized with mental illness.<sup>388</sup> Moreover, the study indicated, consistent with previous studies, that persons with depression had higher levels of violence than did those with a diagnosis of schizophrenia,<sup>389</sup> a finding inconsistent with general perceptions. This suggests that the culprit is drugs and alcohol, not mental illness. Accordingly, no empirical data supports opposition to mental health advance directives based upon fears of violence.<sup>390</sup>

#### D. *A Philosophical Divide*

Lawyers are either the saints or the villains in the mental health field as a result of their role in gaining rights for the mentally ill. With the increase in these rights came the correlative decrease in simply acting upon these individuals. Naturally, then, legal advocates praise advance directives,<sup>391</sup> which are a legal tool to implement the exercise of rights, whereas doctors are more skeptical.<sup>392</sup> It borders on the simplistic, of course, to reduce the divide to lawyers versus doctors, but it often seems to play out that way. It is fair to generalize that lawyers are concerned with clients' rights and doctors with patients' treatment.<sup>393</sup> Looked at this way, the

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(1999).

<sup>385</sup> Heilbrun & Witte, *supra* note 384, at 747.

<sup>386</sup> MACARTHUR VIOLENCE RISK STUDY, *supra* note 379.

<sup>387</sup> *Id.*

<sup>388</sup> *Id.*

<sup>389</sup> MACARTHUR RESPONSE, *supra* note 343.

<sup>390</sup> The MacArthur findings were surprising, insofar as they were contrary to public perception. The National Review criticized them as "politically correct" in their minimization of the violent tendencies of the mentally ill and as lending ammunition to those who wished to repeal involuntary hospitalization laws. See Sally Satel & D.J. Jaffe, *Violent Fantasies*, NAT'L REV., July 20, 1998, at 36. The MacArthur study authors responded with vigor. See MACARTHUR RESPONSE, *supra* note 343, for the full response.

<sup>391</sup> See, e.g., Winick, *supra* note 6, at 89.

<sup>392</sup> See, e.g., Paul Chodoff & Roger Peele, *The Psychiatric Will of Dr. Szasz*, 13 HASTINGS CENTER REP. 11 (1983).

<sup>393</sup> But see Stavis, *supra* note 138, at 4-16. Professor Stavis has criticized the development of rights for the mentally ill, suggesting that in the name of civil

players on each side of the debate are predictable and, indeed, understandable, as the discussion regarding advance directives is very much about rights versus treatment. Even in the face of this divide, however, some mental health professionals have praised mental health advance directives.<sup>394</sup> Use of this instrument will encourage patient involvement in treatment, promote autonomy, and ensure better knowledge of the illness through the process of counseling that should precede an advance directive.<sup>395</sup> Conversely, some legal experts acknowledge and laud the potential therapeutic effect of an advance directive through which a consumer chooses treatment rather than rejects it.<sup>396</sup>

It is also true that each side appears and argues through its own bias; neither can claim a corner on the truth.<sup>397</sup> But if we know nothing else as a result of this four-decade explosion of issues in mental health, it is that both treatment and rights change rapidly and markedly.<sup>398</sup> Accordingly, a dose of humility on the part of all contributing to this area is a medicine we should voluntarily swallow.

## VI. CONCLUSION

Mental health advance directives still hold potential for being a newly fabled "third way." They are an instrument through which, in most cases,

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rights, the courts have impeded treatment and diminished patient autonomy. *See id.* at 2.

<sup>394</sup> *See* Deborah S. Pinkney, *Advance Directive Could Give Mentally Ill More Treatment Control*, AM. MED. NEWS, Dec. 16, 1991, at 3; Marilyn K. Rosenson & Agnes Marie Kasten, *Another View of Autonomy: Arranging for Consent in Advance*, 17 SCHIZOPHRENIA BULL. 1, 1-3 (1991) (defending Ulysses contracts and critiquing the self-paternalism argument raised in opposition to advance directives).

<sup>395</sup> *See* Backlar, *supra* note 161, at 262.

<sup>396</sup> *See* Stavis, *supra* note 138, at 72-75; Winick, *supra* note 6, at 81-86.

<sup>397</sup> Dr. Robert Miller, for instance, in his critique of mental health advance directives, lambasts lawyers (and libertarians) for promoting ideological agendas, yet his article does nothing less than promote his ideologies. *See* Miller, *supra* note 283, at 745. Others have noticed this "excess of finger-pointing and blame-attributing." *See* Perlin, *supra* note 348, at 24.

<sup>398</sup> Psychopharmacological treatment has moved forward in leaps and bounds. The development of legal rights, however, has slowed for a variety of reasons. There are fewer patients in psychiatric hospitals, for instance, thus reducing the need for institutional litigation. *See* John W. Parry, *Executive Summary and Analysis*, 21 MENTAL & PHYSICAL DISABILITY L. REP. 707, 707 (1997). There are now restrictions on class actions brought by legal services lawyers and other reasons that attribute to the legal slow-down. *Id.* Further, "there has been a litigation deemphasis in favor of other advocacy methods, particularly non-class action systems advocacy." *Id.*

all involved parties can reach agreement.<sup>399</sup> Most persons recognize both the legal primacy and moral value of autonomy. Further, most persons recognize that there is mental illness and that treatment, often through psychopharmacology, can be valuable. Most also acknowledge, however, that drug treatment can be ineffective and dangerous at its worst and yields irksome side effects nearly all of the time. Finally, most people agree that persons with mental illness are often competent to make decisions.

Mental health advance directives take advantage of these areas of agreement. They permit persons with mental illness to assert their right to autonomy while competent. This assertion of rights can permit persons with mental illness to plan in advance their treatment choices for when they might become incapable of making such choices. This act of planning is more than an exercise in self-determination—it also has salutary therapeutic effects. So far so good. Now comes the part where the agreement might disintegrate, but a truce is still possible.<sup>400</sup> Some persons will choose treatment; some persons will refuse it. Sometimes the same person will opt for a little of each, or a modification of the treatment plan suggested—to the consternation, no doubt, of those who propose it. But to choose is their right and to be encouraged to choose while they are able may be our responsibility—the families, the advocacy groups, the doctors and, yes, the lawyers, who each see so clearly the solution but who, as of yet, have not solved the problem.

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<sup>399</sup> If agreement is too sanguine a term, then perhaps a truce.

<sup>400</sup> Hoping for a truce may signal either a capitulation or a recognition that the truth is somewhere in the middle. In either case, the reach for a third way is consistent with recent scholarship on therapeutic jurisprudence, which has been described as seeking compromise or a “convergence of various interests.” David B. Wexler, *Therapeutic Jurisprudence and the Culture of Critique*, 10 J. CONTEMP. LEGAL ISSUES 263, 273 (1999). Initially (and perhaps still) a bit skeptical of therapeutic jurisprudence with its paternalistic ring, if acknowledging some merit on each side of the debate puts me in its camp, I am happy to pitch my tent.